Hertfordshire Domestic Abuse Partnership

Welwyn and Hatfield Community Safety Partnership

Domestic Homicide Review

Overview Report

Into the death of Celeste (pseudonym) in September 2021

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Independent Domestic Homicide Review Chair and Report Author

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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.

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. Timescales

3.1 On 27th October 2021 the Strategic Partnerships Team of Hertfordshire County Council received a Domestic Homicide Review Referral relating to Celeste from Hertfordshire Constabulary. Following an initial information sharing gathering exercise with a range of local statutory and voluntary sector agencies a decision was made by the Chair of the Strategic Partnerships Team together with the Chair of the Community Safety Partnership to commission a review as a result of the criteria being met and the opportunity to learn from this tragic incident. It is the responsibility of the Strategic Partnerships Team to coordinate Domestic Homicide Reviews on behalf of the County's 10 Community Safety Partnerships.

3.2 The Home Office Multi Agency Statutory Guidance advises that where practically possible the DHR should be completed within 6 months of the decision made to proceed with the Review. Between September 2021 and January 2022, there were a steep increase in the number of domestic homicides being committed in Hertfordshire. During this short period there were four homicides which met the criteria for a Domestic Homicide Review. This exceeded the average number of domestic homicides in Hertfordshire in a year. Unfortunately, this increase was also seen by other local areas and therefore the impact on availability of accredited and independent chairs for DHRs was significant, with many of those contacted not being able to take on new DHRs until at least the beginning of summer 2022.

3.3 As a result of the above, the Strategic Partnerships Team together with the Community Safety Partnership agreed to undertake a Rapid Review into these four

incidents. The purpose of the Rapid Review for Celeste was to identify any urgent learning for how the partnership could better safeguard victims of domestic abuse and prevent further homicides. The learning identified as part of this process has been included in this Domestic Homicide Review for completeness. Family members were not involved in the Rapid Review process; therefore the learning reflected the organisation's experiences as opposed to Celeste and her family members experiences.

3.4 An Independent Chair was commissioned to begin the Domestic Homicide Review from October 2022. Panel meetings took place in October 2022, January 2023, February 2023, March 2023, July 2023 and September 2023. The Review also was undertaken in parallel to the Mental Health Homicide Review which was commissioned by NHS England in relation to the care received by Alfred as the perpetrator of this domestic homicide. The Review was completed in February 2024, following comments received by Celeste's family in January 2024, and forwarded to the Home Office at this time with the Mental Health Homicide Review appended. The Overview Report was also shared with the coroner at the conclusion of the review.

4. Confidentiality

4.1 The findings of this Review are restricted to only participating professionals and their line managers, until after the Review has been approved by the Home Office Quality Assurance Panel.

4.2 As recommended within the 'Multi Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews' to protect the identity of the deceased, and her family, the following pseudonyms have been used throughout this report.

4.3 The name Celeste is used for the deceased, who was 48 years at the time of her death and chosen by her family. The name Alfred is for her husband, a pseudonym chosen by the Review Panel he was 48 years at the time of his death. Both Celeste and Alfred were White British.

4.4 After this Overview Report has been through the Home Office Quality Assurance process, a decision on whether to publish it will be made by the Strategic Partnerships Team. If it is to be published, the Report and appendices will firstly be fully redacted.

4.5 A redaction may simply replace a name with a pseudonym, or may be the removal of personal and sensitive details about an individual, i.e., medical information. Redactions will not be used to protect the identities of the organisations participating in the Review.

4.6 The sharing of information between organisations in relation to the Review was all underpinned by a Confidentiality Statement which each individual read and signed at the beginning of the review (Appendix B). An information sharing protocol was and currently is in place which all agencies represented on this panel are signatories to, this agreement is underpinned by the Crime and Disorder Act 1998 which the Strategic Partnerships Team have in place, supported by the Community Safety Partnership.

5. The Terms of Reference

5.1 Specific Terms of Reference for this Review:

5.1.1 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:

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

5.1.3 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.

5.1.4 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.

5.1.5 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.

5.1.6 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?

5.1.7 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?

5.1.8 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?

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

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

5.1.11 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?

5.1.12 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.

5.1.13 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.

5.1.14 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.

5.2 Key lines of enquiry

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

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

5.2.2 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.

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

5.3 Legal advice and costs

5.3.1 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.

5.3.2 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.

5.4 Media and communication

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

5.5 Roles and Responsibilities

Chair of Strategic Partnerships Team

5.5.1 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

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

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

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

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

5.5.6 To write the Overview Report and Executive Summary

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

6. Methodology

6.1 Thirteen agencies/multi-agency partnerships/departments were contacted about this review initially in the Hertfordshire area and these are listed in Appendix D. The decision to undertake this review is referred to in Section 3.

6.2 The following agencies confirmed that they had had relevant contact with either Celeste or Alfred, and therefore were asked to undertake an IMR. These were:

- East and North Hertfordshire NHS Trust
- Hertfordshire Partnership University NHS Foundation Trust
- Hertfordshire and West Essex Integrated Care Board- GP Practices (Peartree Group and Hall Grove)

6.3 Independent Management Reviews (IMRs) were commissioned by the Independent Chair in October 2022. Four agencies undertook an IMR and presented this back to the Panel in January 2023. The purpose of an IMR is for the individual organisation to scrutinise their involvement in the case and establish whether policies and practices were adhered to or not. Following this review, the organisation may make recommendations to improve their response to domestic abuse as a result of this case.

6.4 IMRs were written by separate individuals to those who represented the organisations on the Panel in order to best support the independent scrutiny element of this choice of methodology and in line with best practice from the Statutory Guidance. Helpfully, the two GP Practices were able to present their IMRs to the DHR Panel alongside their Panel representative from the Integrated Care Board. The Chair praised the GP Practices for their dedication and interest to support the review.

6.5 This Report has been compiled using information and facts from the following:

- Individual Management Review (IMRs) presentations as above
- A chronology of events leading to the death of Celeste, coordinated and produced by Strategic Partnerships Team.
- Discussions during the Review Panel Meetings.
- Conversations with Celeste's family members.
- Mental Health Homicide Review, written by Anne Richardson Consultancy
- Serious Incident Report provided by Hertfordshire Partnership University NHS Foundation Trust
- The findings from the Rapid Review undertaken in summer 2022, these were the following;

Staff are confident in making referrals to MARAC and the IDVA service, where the consent of the service user is not required.

Seeing patients alone- owing to concerns of domestic abuse was not standard policy.

Frequency of domestic abuse enquiry by the Acute Health Trust provider was underpinned by a specific set of circumstances.

Concerns that 'gatekeeping' referrals from health into MARAC looked different to other agencies.

Lack of comprehensive domestic abuse training to staff within the health economy

Concerns and barriers to GPs making clinical enquiries with patients around domestic abuse owing to changes in how consultations are delivered and training gaps.

7. Involvement of family, friends and wider community

7.1 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.

7.2 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.

8. Contributors to the Review

8.1 Whilst there is a statutory duty that bodies including, the police, local authority, probation and health authorities must participate in a DHR; in this case ten organisations voluntarily contributed to the review from the Hertfordshire Domestic Abuse Partnership. These were the following;

- Hertfordshire Constabulary
- Hertfordshire County Council
- East and North Hertfordshire NHS Trust
- Refuge
- Hertfordshire Partnership University NHS Foundation Trust
- Hertfordshire and West Essex Integrated Care Board
- Hall Grove GP Practice
- Peartree Group GP Practice
- Welwyn Hatfield Borough Council
- Spectrum CGL

8.2 Celeste's family members have also contributed to this review as previously advised in para. 7.1.

9. Multi Agency Review Panel

9.1 The Review Panel consisted of senior managers, from both the statutory and voluntary sector, listed below. All of the organisations that have been part of the Review have assisted in the identification of lessons and committed to implementing action plans to address the lessons. All Panel members have also undertaken the Home Office DHR Panel training and signed confidentiality statements.

9.2 The membership of the Multi Agency Review Panel included the following;

Faye Kamara LLB, MSc- Independent Chair

Beth Goodall, Business Support Officer, Hertfordshire County Council

Sarah Corrigan, Safeguarding Lead, East and North Hertfordshire NHS Trust

Louise Bayston, Senior Operations Manager, Refuge

Vikki Symonds, Service Manager, Refuge

Anne Richardson, Commissioned Consultant- Mental Health Homicide Review Report Author

James Luxon, Detective Chief Inspector, Hertfordshire Constabulary

Karen Hastings, Head of Social Work and Safeguarding, Hertfordshire Partnership University NHS Foundation Trust

Sheelagh Coe, Associated Director Adult Safeguarding Hertfordshire and West Essex Integrated Care Board

Leanne Naughton, Senior Social Worker and Safeguarding, Spectrum CGL

Sue McDaid, Director (Resident and Neighbourhood), Welwyn Hatfield Borough Council

Clara Claydon, Community and Intervention Team Leader, Welwyn Hatfield Borough Council

The Review Panel was also supported with valuable contributions from;

- Peartree Group GP Practice
- Hall Grove GP Practice

9.3 The Panel sought the expertise of the specialist domestic abuse support service within the Hertfordshire County to support DHR Panel discussions on what further work could be undertaken in future to support couples where there are mental health concerns for both the victim and perpetrator. Expertise was also sought from the local Drug and Alcohol Support Service owing to the alleged perpetrator's drug and alcohol misuse historically, which ended in 2020.

9.4 The Independent Chair and the Review Panel members offer their deepest sympathy and condolences to Celeste's family. The Chair would also like to thank the Review Panel who have contributed to the deliberations of the Review, for their time, honesty, transparency and cooperation.

10. Author of the Overview Report

10.1 The Chair of the Panel possesses the qualifications and experience required of an Independent DHR Chair, as set out in section 5.10 of the Home Office Multi- Agency Statutory Guidance. She has worked as a practitioner, commissioner of services for survivors and a consultant in the domestic abuse sector. She dedicated her Masters of Science to 'What works when working with domestic abuse perpetrators of domestic abuse'. She is not associated with any of the agencies involved in the Review nor had she had any dealings with Celeste, and she is totally independent. She has undertaken the AAFDA (Advocacy after Fatal Domestic Abuse) DHR Chair Training, is an experienced DHR Independent Chair/Report Author and is passionate about improving the responses to domestic abuse both locally and nationally.

11. Parallel Reviews

11.1 Further to paragraph 3.3 a Mental Health Homicide Review was also commissioned, following this incident, by NHS England, to focus on learning from the mental health support the alleged perpetrator, Alfred, accessed during this time. This review was undertaken in parallel to the DHR, and the consultant commissioned to lead the Mental Health Homicide Review was also a DHR Panel member as per paragraph 9.2.

11.2 The Coroner's Inquest is still outstanding. It is intended that the Overview Report will be shared with the Coroner's Office on completion of a final version.

12. Equality and Diversity

12.1 The Panel have been committed to the Review, within the spirit of the Equalities Act 2010, and have demonstrated an ethos of fairness, equality, openness and transparency. The Panel have worked as a partnership in ensuring that the Review has been conducted in line with the Terms of Reference. The Review has been cognisant of Celeste's family and their privacy. Both Celeste and Alfred's families were contacted as part of this Review to ascertain their views about Celeste's lifestyle, interaction with agencies and her relationships.

12.2 The practices of agencies were carefully considered to ascertain if they were sensitive to the nine protected characteristics of the Equality Act 2010 ie. Age, disability, gender reassignment, marriage and civil partnerships, pregnancy and maternity, race and religion and belief, sex or sexual orientation. In line with the Terms of Reference, the Panel considered these protected characteristics and concluded that given Celeste's mental health diagnosis this was a factor relevant to the review. Section 6 of the Equality Act defines disability as when a person has a physical or mental impairment which has a substantial and long-term adverse effect on their ability to carry out normal day-to-day activities. As reported by Celeste and her family, on occasion this mental health diagnosis would prevent her from carrying out day to day activities. Hence why she was well supported by Hertfordshire Partnership University NHS Foundation Trust, and the majority of agencies that had any rapport with her; GP Practice and Mental Health Trust were well sighted of her mental health needs. Celeste's family reported as part of this review that she managed her wellbeing and illness extremely well. There was no evidence in the records held by agencies that there was ever any question of Celeste's mental capacity, therefore no formal assessment of capacity was ever required.

12.3 Celeste was a white British female with English being her first language, however she spoke fluent French and loved visiting family and friends in France. Celeste married Alfred later in life and her family reported as part of this review that they had a good relationship together. Celeste did not have any children.

12.4 Alfred was a white British male with English also as his first language. We understand from this review that he also had some significant mental health issues and physical health concerns during the time of this review and before the incidents of late 2021. No agency held information that indicated that he lacked capacity to make decisions and there was no indication from the resources analysed as part of this review that a formal assessment of capacity was ever required for him. It was acknowledged as part of this review that Alfred did have mental health and physical health needs which often conflicted with one another. He would present all of his issues to several practitioners possibly leading professionals to think that other things were in hand owing to the frequency of contact with various health agencies and diagnostic overshadowing. Diagnostic overshadowing is a term used to describe a situation where a health professional makes the assumption that the behaviour of the person is part of one aspect of their health need without exploring other factors as biological determinants. The source of Alfred's symptoms associated with chronic abdominal pain were not identified by health professionals. However medical tests were ongoing.

12.5 The above factors were all considered as part of this review. Research does tell us that women are more likely to be victims of domestic abuse than men, this is also true where mental health is a significant factor. Safelives (2019) found in their studies that there was a strong association between having mental health problems and being a victim of domestic abuse, and that those who already have a preceding mental health condition and then go on to experience domestic abuse can intensify their problems.

13. Dissemination

13.1 Actions to be taken after presentation of the Overview Report to the Welwyn and Hatfield Community Safety Partnership.

13.2 The partnership should:

- Provide a copy of the Overview Report and supporting documents to the Home Office Quality Assurance Group. This should be via email to DHRENQUIRIES@homeoffice.gsi.gov.uk
- The document should not be published until the partnership has received confirmation from the Home Office that the report has passed the Quality Assurance process.
- In preparation of publication, the Partnership should agree and sign off the content of the Overview Report for publication, ensuring that they are fully anonymised, apart from the names of the Review Panel Chair and members.

13.3 On receiving clearance from the Home Office Quality Assurance Group, the Welwyn and Hatfield Community Safety Partnership with Hertfordshire Domestic Abuse Partnership should:

- Provide a copy of the Overview Report and supporting documents to the senior manager of each participating agency listed in Section 8, including individually each of the Panel members listed in Section 9.
- Decide whether an electronic copy of the Overview Report (this must be carefully redacted) and Executive summary should be published on the Hertfordshire County Council website. Only where necessary and for safeguarding reasons or wishes of the families involved in the review will the Report not be published.
- Monitor the implementation of the specific, measurable, achievable, realistic and timely (SMART) Action Plan.
- Formally conclude the review when the Action Plan has been implemented and consider an audit process.
- Make arrangements to provide feedback and debriefing to staff, family members and the media as appropriate.

14. The Facts

14.1 Celeste was brought up in Hertfordshire and lived in the County her whole life. Her mother was from France, and this was the only other place she called home. Celeste sadly was experiencing some ‘ongoing issues’ as per the GP records with her mental health from approximately 1998, and subsequently twelve years later in 2010 she was diagnosed with Schizophrenia by a psychiatrist at Hertfordshire Partnership University NHS Foundation Trust. Since this time, she was cared for by this Trust and numerous teams within this organisation dependent on her needs. Her family reported as part of this review that she managed her illness well and would often speak up when she was struggling to cope.

14.2 In 2013, Alfred was diagnosed with having a Depressive Disorder with psychotic symptoms by the same Trust; Hertfordshire Partnership University NHS Foundation Trust. Alfred was initially treated with some medication, and was signposted to other services to ascertain ongoing support. His engagement with these services was sporadic. In 2017, there was one domestic incident reported to the police by a third party involving Celeste and Alfred. It was reported that there was noise coming from their address and concerns regarding a domestic incident. Police attended following what was policy and practice at that time, and it was recorded on their systems that there was no disturbance. Celeste and Alfred both advised that they were fine, and all was well. No further action was undertaken. There were no other significant events according to agency records until the following year in 2018 when there appeared to be more frequent admissions by Celeste of experiencing increased OCD symptoms when she attended her regular clinic for a medication review. Her wellbeing was often reviewed as part of her attendance at clinic and regularly she spoke of how she was happy in work, going on holidays etc..

14.3 It was also noted that in 2018, Alfred was regularly attending his GP Practice with various concerns; abdominal pain and skin conditions as examples. In addition he also attended A&E where he was diagnosed with cellulitis in his foot. At the same time, Celeste had also approached her GP Practice reporting that her mood was a bit lower, however she denied any thoughts of self-harm. By the end of 2019, Celeste was reporting to Hertfordshire Partnership University NHS Foundation Trust that her OCD symptoms were better, she had left her paid job and started some voluntary work and was feeling less stressed and anxious. In this latter consultation she was accompanied to the appointment by her mother. Most appointments she attended alone in 2018.

14.4 At the start of 2019, Alfred was referred to a gastroenterologist for some further investigations after he consistently reported concerns with ongoing abdominal pains. Blood tests had also highlighted that he had a fatty liver and that there was a need for him to lose weight and cut down on alcohol, which Alfred agreed.

14.5 On 14th March 2019, Celeste and Alfred got married. Family reported as part of this review that this was a very happy day for the couple and their families. Celeste and Alfred had already been together over 20 years at this point. Celeste's family reported as part of this review that the couple decided to marry for financial security for the surviving spouse. They further reported that Celeste was very happy and continued after this date to tell others whom she came into contact with, including the mental health workers at the end of March 2019 how much of a wonderful time she had had.

14.6 In early April 2019, Celeste reported to her GP that she was experiencing palpitations and therefore a referral was made to cardiology for Celeste to be seen as an outpatient. The following month Alfred attended A&E with the same palpitations and chest pain in his left side and left shoulder area. It is unclear whether Celeste was seen for her cardiology appointment on 16th August 2018 as scheduled, and it was recorded that she was discharged from the service. Alfred's palpitations were managed by being signposted back to out of hours GP services that day and later he did have some medication which resolved the concerns by the end of the year. Later in the same month in August 2019, Celeste met with her Consultant Psychiatrist from Hertfordshire Partnership University NHS Foundation

Trust and advised that she was experiencing a low mood due to not working and missed being financially independent of her partner. She also said that she continued to experience OCD symptoms. According to the agency records, there was a further discussion led by the consultant exploring the context of the lack of income to ensure that there was no indication of financial abuse or control. The Consultant was satisfied that this was just a change in circumstances and not about control. Celeste also advised that she was looking forward to a holiday with Alfred.

14.7 In the latter part of 2019, Celeste got a new job at a supermarket- providing support in the canteen for staff. Alfred was seen by numerous health services for concerns with his physical health ie. Cardiology and gastroenterology. This continued into early 2020 with another attendance at A&E in January 2020 with concerns he had for his physical health which resulted in an endoscopy with some minor findings but nothing significant. The following month Alfred reported to the GP Practice that he also had concerns for prostate cancer. Alfred also advised as part of this consultation that he had stopped drinking alcohol and had turned his life around after a lot of health issues.

14.8 In April 2020, Celeste was seen by her consultant for her annual care review. She reported symptoms of anxiety and that her OCD had worsened again given the pandemic (Covid-19) but that she was trying to cope. She advised that her and her husband were trying to keep themselves occupied. She had been furloughed due to the pandemic and therefore was not working. It was recorded in the agency notes that no discussion was had with regards to whether her needs or her husband's needs as carer had changed due to the pandemic. Celeste was reviewed at home in May 2020 owing to her previous consultation and it was recorded that she was able to manage activities for daily living at home and there were no other concerns. During this same time, Alfred had numerous consultations with his GP Practice in relation to; dental issues relating to a filling and swelling around the ankle with an episode of gout. On 4th June 2020 he shared with the GP Practice that he was having some 'dark thoughts'; these included harming his mother, sister and dog. He said that these thoughts did just come out of the blue, he didn't have any thoughts of deliberate self-harm/suicide and was not drinking alcohol. The GP reviewed all of the medications that Alfred was prescribed for his physical and mental health issues, and a referral to the mental health nurse within the GP Practice was made to assess Alfred's mental wellbeing. This assessment took place on 16th June 2020.

14.9 At the assessment he reported that following his new medication his thoughts had subsided and he did not feel at risk currently to self or others. He advised that he struggled with sleep, and that although he could get to sleep, he couldn't stay asleep and therefore was only getting about 1.5-2 hours sleep per night. Alfred agreed that he should be referred to Hertfordshire Partnership University NHS Foundation Trust Community Mental Health Services based on the restart of specific medication and the potential for ongoing negative thoughts and support with this. The GP Practice made this referral to mental health services the same day, this was necessary as Alfred was not an open case to the local Mental Health Trust; Hertfordshire Partnership University NHS Foundation Trust at the time. Hertfordshire Partnership University NHS Foundation Trust responded the following day advising that it had been stepped down to routine and the patient would be assessed within 14 days. During the same period Alfred did have direct contact with a Consultant Psychiatrist at

Hertfordshire Partnership University NHS Foundation Trust following a request to review his medication, this was a clinician from the single point of access service. This was via telephone on 18th June 2020 where Alfred reported previous issues with substances but was now free of these at present. He also described once again his fleeting thoughts about harming other people, but this did not step into intending harm to others. The Consultant Psychiatrist contacted the GP Practice the following day advising that they suspected Alfred was over aroused due to the withdrawal of alcohol and drugs and that drugs were no longer clouding his mind. The Consultant Psychiatrist also advised on his medication review and levels and that he would require a face to face assessment for diagnosis and monitoring.

14.10 Before the end of the month Alfred had contact from Hertfordshire Partnership University NHS Foundation Trust again- this was to arrange his initial assessment and medication review following both the referral from GP Practice and what the Consultant Psychiatrist had suggested.

14.11 As a result of Covid-19, Celeste's care and medication was being managed via telephone consultation only at this time in June 2020. Celeste made a call to Hertfordshire Partnership University NHS Foundation Trust and left a message on 26th June 2020, later that day her call was returned by a Consultant Psychiatrist where she reported that she had been feeling ok for the last two weeks following a change in her medication dosage. However, she did also report some anxiety due to the pandemic and added that her husband was of great support.

14.12 The following day on 27th June 2020, Celeste attended the Urgent Care Centre with a head injury and was seen face to face by an Emergency Nurse Practitioner (ENP). Celeste reported that she had 'fell last night and hit her head on concrete whilst intoxicated'. It was noted by the nurse that Celeste kept looking at Alfred and when he was asked to leave (due to covid restrictions) he was reluctant to leave. She was noted to present as anxious and unwashed. When she removed her mask (owing to Covid restrictions) there was a bruise on her cheekbone and when her jumper was removed there was further bruising observed on both arms. Celeste was asked how she got her bruises and she responded with 'I bruise easily'. It was also noted that further bruising on her left shoulder was also identified. As a result of this, the nurse asked Celeste whether she was in an abusive relationship and whether anyone was hurting her, she was reassured that she was in a safe place and that her response would remain confidential. Celeste's response was that she was not in an abusive relationship and that no one was hurting her, the nurse asked if she consented to a referral being made to Safeguarding Adults, Celeste agreed to this. Although Celeste did not say that she was experiencing abuse the nurse sought advice from the Trust's safeguarding team and to support the referral to Safeguarding Adults.

14.13 Three days later on 30th June, Alfred had a telephone consultation with a Consultant at Hertfordshire Partnership University NHS Foundation Trust. He reported experiencing thoughts of harming his wife, mother and dog but denied the intention to do so. He advised that his sleep was reportedly disturbed but denied any suicidal or homicidal ideations. Alfred agreed to having his medication adjusted but refused a referral to drug and alcohol services.

14.14 On 1st July 2020 Alfred presented to A&E with a suspected overdose to medication and he refused intervention at the time by mental health liaison services. Hertfordshire Partnership University NHS Foundation Trust attempted to call Celeste on 9th July 2020 however there was no reply or facility to leave a message. On 20th July 2020 she was visited at home by the Adult Community Mental Health Service for routine monitoring of her bloods owing to the medication she was prescribed and taking. It was recorded that Celeste was identified as having a Covid RAG (Red, Amber, Green) rating of Red and was under the low intensity team. This RAG rating was developed to ensure individuals with most risk of experiencing significant symptoms should they contract the disease were more closely monitored. The rating also recognised additional risks and complexities (for example, where there was significant social or safeguarding needs, those individuals were also rated Red). In Celeste's case, the rationale for the Red rating was due to her diagnosis where it was recognised that undue stress related to the pandemic may also impact mental health, increasing the likelihood of resumption of symptoms of schizophrenia. Additionally, Celeste was taking Clozapine, a medication which has to be monitored via regular blood tests as it can have severe adverse side effects, and at the time it was unknown how people on this medication would be impacted by the virus.

14.15 During this time, the Covid-19 pandemic was still relatively new. Hertfordshire Partnership University NHS Foundation Trust had in place a command and control system to manage their services and risks to patients of the covid-19 infection. Celeste was identified as red owing to the anti-psychotic drugs that she was prescribed and that her condition was known to be affected more significantly by the virus.

14.16 Celeste continued to receive home visits from the FACT team at Hertfordshire Partnership University NHS Foundation Trust, however these were not daily visits in July, August and September. It was noted each time that the visit was to monitor and manage her medication and no issues were noted.

14.17 Alfred presented to GP Practice with concerns about his knee in late September 2020 and was advised to book an appointment with physiotherapy and an x-ray was organised. There were also a number of correspondences in early October between Hertfordshire Partnership University NHS Foundation Trust (Consultant Psychiatrist), GP Practice and pharmacist on how Alfred's mental health would be managed. Alfred's knee following Xray appeared to be normal with some mild degenerative changes but no significant concerns.

14.18 Celeste reported as part of her consultation with Hertfordshire Partnership University NHS Foundation Trust that she was struggling with her anxiety, OCD and paranoia was getting worse at the end of October 2020 and requested an increase in her medication. This was followed up with a phone call from her Consultant Psychiatrist, where it was also noted that her husband Alfred and family were supportive. Celeste's medication continued to be delivered to her home address during November. On one occasion Celeste was reportedly at work and not in. It was recorded that Alfred advised that there were no new concerns at the time of the visit. Alfred also reported to his Consultant Psychiatrist at Hertfordshire Partnership University NHS Foundation Trust during the same time period that he was struggling to sleep again, however his GP had prescribed some new medication

for this the day before. Just a short while later, Alfred presented to A&E with concerns over chest pain and slightly short of breath. An examination showed some tenderness however nothing abnormal was detected and he was reassured and discharged home the same day.

14.19 On 2nd December 2020 Alfred spoken to a specialty doctor over the phone at Hertfordshire Partnership University NHS Foundation Trust. He reported that his current medication had reduced his morbid thoughts and he was compliant with the medication he was taking. By his own admission he reported that he still had thoughts of harming others however they had reduced, and he had no active plans to cause harm. He did also report that he was only sleeping 4 hours per day, but this was an improvement. This update was shared with Alfred's GP Practice for awareness and to confirm that the care plan had been agreed with Alfred re medication. Alfred was also reminded of numbers to contact in the event of a crisis and to only drink alcohol in moderation.

14.20 Six days later on 8th December 2020, Celeste spoke with her Consultant Psychiatrist on the phone and reported that she was going through a bad patch and was feeling anxious. She said that she had stopped working as she was getting stressed. She also said that she thought people were looking at her and laughing when she was out walking with the dog. She denied feeling suicidal. Two days later when she had a home visit for her medication management, it was recorded within the notes that she presented as anxious and paranoid, refusing to allow one of the workers inside her home address. The following day Celeste's mother also made contact with the same service and spoke with Celeste's Consultant Psychiatrist to raise some concerns about Celeste's deterioration. Celeste's mother provided an example of what Celeste had shared with her which reminded her of when Celeste was significantly unwell previously. Celeste's mother was advised that Celeste's medication had been increased with the aim of settling some of her symptoms. Celeste was seen in clinic for her medication management in early January 2021 with no concerns raised.

14.21 Celeste was seen by her Consultant Psychiatrist in person on 11th January 2021, she reported feeling anxious and paranoid. She said that the increase in her medication dose had helped in making her feel less troublesome. It was noted in the record that risks had been assessed and she denied feeling suicidal. When asked whether she had support networks around her, she said that her husband and mother were supportive and knew that she was not well.

14.22 Alfred contacted his GP Practice on 25th January 2021 with concerns over bowel cancer and was feeling anxious. The GP Practice suggested that he attend the surgery for an examination. It was unclear whether he did attend the following day for this examination or not. Nevertheless, as well as his physical health Alfred was also reporting at this same time, 27th January 2021, to Hertfordshire Partnership University NHS Foundation Trust that he was having 'horrendous thoughts' regarding his wife and mother becoming harmed. Alfred described 'snapping' at his wife and becoming agitated at home. He reported he 'wasn't going to do anything silly' and requested to speak with the doctor about these intrusive thoughts. Alfred discussed these thoughts with a specialty doctor the same day and he explained that one of the thoughts involved his wife getting covid. He did not describe any plans to harm any family member. There was no discussion in relation to his caring role for Celeste and whether extra support might be appropriate. This information was shared with

Alfred's GP Practice albeit according to records this was not received until 8th February 2021.

14.23 Celeste attended the clinic for management of her medication and also phoned her Consultant Psychiatrist asking for a phone consultation on 1st February 2021. The following day the Consultant Psychiatrist contacted Celeste via phone. Celeste advised that she was feeling less paranoid since the increase in her medication, however she was still feeling quite anxious. She added that her anxiety was much worse before the increase in medication when she was using alcohol to calm herself down and has since stopped drinking about 10 days ago. She advised that she had been using diazepam on and off instead and would like a one off prescription of this, the Consultant Psychiatrist agreed to this in the short term so that she could manage her anxiety and was advised on the dose to be taken. She also reported that her OCD symptoms remained a problem and therefore Celeste and the Consultant Psychiatrist agreed to change her dose to manage this. There were no other concerns or risks mentioned or discussed.

14.24 There was one record of Alfred making further contact with his GP Practice in late February 2021 regarding abdominal pain. It was agreed that Alfred should attend the practice the following week (as it was a Friday) for a face to face appointment to explore irritable bowel syndrome or possible gallstones as an explanation for the pain he was suffering from.

14.25 Celeste had further contact with her Consultant Psychiatrist on 9th March 2021 via phone. During this consultation Celeste reported that she was feeling up and down and was continuing to experience strange and weird thoughts which she did not want to discuss. Her OCD symptoms were worse when she had to leave home. She said that she was making sure that she stuck to a routine and took the dog out for a walk daily. Celeste also reported reducing her alcohol intake from daily to just a few glasses of wine at the weekend. No other concerns were raised, or risks identified. Later the same month Alfred had a telephone consultation with a specialty doctor. Alfred advised that he was complying with his medication and was not taking illicit substances or recent alcohol misuse. Alfred also shared with this professional that 'he was providing care to his wife who had mental health issues.' There was no evidence that this had been discussed in detail with Alfred nor that a carer assessment was offered to increase the support to either Alfred or Celeste in the event of either being in hospital. Over those next couple of days Alfred's abdominal pain worsened and he reached out to the 'out of hours' for advice. He was provided with some advice and this information was shared back with his GP Practice for information, including the need to understand the outcome of the gastroenterology investigations. At the same time Celeste also reported to her Psychiatrist via phone that she was feeling more anxious and was worrying a lot more mostly about whether if anything happened to her what would happen to her family. They discussed an increase in some of her medication to manage these symptoms which she agreed to. Celeste was seen in clinic a few days later for her medication management and no further issues were noted.

14.26 On 2nd April 2021, Alfred contacted his GP Practice about some itchy spots on his arms and torso. He was advised that this was highly likely to be eczema and was prescribed some ointment. A week later on 8th April 2021, Alfred spoke with his Consultant Psychiatrist

and advised that he was not very well and was undergoing investigations for his physical health. He admitted that he was finding it difficult to look after his wife as he himself was feeling poorly and requested some help with her. Alfred reported that she had given consent for the consultants involved in their care to discuss this. It was recorded in agency notes that Alfred at this point was offered a carer assessment and he declined this. Just short of another week later, on 14th April 2021, Alfred left a message for his Consultant Psychiatrist via phone reporting that he was feeling much better mentally, although his physical condition he was finding overwhelming and would like to request that his medication is reduced. This was agreed via phone 4 days later and communicated to the GP Practice.

14.27 On 21st April 2021 Alfred contacted the Hertfordshire Partnership University NHS Foundation Trust reporting that he had some difficulties with sleeping which he recognised usually precedes a decline in his mental health. He also expressed concern for a deterioration in his wife's mental health condition. It was agreed that a change in medication was required for him, no other risk issues were noted in the record. Celeste was seen this same week in clinic for her medication management and she reported feeling very anxious and low due to her husband having tests recently.

14.28 On 28th April 2021, there was a review undertaken by colleagues within the Hertfordshire Partnership University NHS Foundation Trust- acknowledging that Alfred was reporting concerns for further deterioration of Celeste's mental health and that she was reporting becoming increasingly more paranoid. It was agreed by the Consultant Psychiatrist that Celeste should be invited into Roseanne House that same day for a welfare check and offered additional support. Alfred was contacted about this and informed of this plan, he asked that the worker did not report to Celeste that this had been the result of him advising of the concerns. It was recorded that Celeste attended Rosanne House where she reported paranoia and other psychotic symptoms. She added that she felt vulnerable in her home, however this appeared to be in relation to feeling that unknown people are targeting her. It was recorded within the notes that when Celeste described herself as feeling vulnerable at home that the context of this was explored and there was no indication of domestic abuse as the cause of this. A plan was agreed with Celeste that the FACT team would visit her for some extra support. This is a mini-team within the Adult Community Mental Health Services providing more intense support for people who may be becoming unwell to prevent deterioration.

14.29 Celeste was visited on 30th April 2021 by the FACT team at home. According to the agency records by Hertfordshire Partnership University NHS Foundation Trust Celeste appeared a little anxious in mental state. Assurances were offered on her paranoid thoughts that were expressed. Medication was discussed and Alfred joined the consultation by introducing himself and explained that his current physical health concerns were causing Celeste distress. It was also recorded by the practitioner that when the FACT worker asked Celeste if she had any concerns, she wished to discuss she felt she wanted to say something but was finding it hard. Celeste did express that she had a nice day with her family the previous day. Upon exploration again Celeste didn't advise of any concerns but was encouraged by the worker to write down any worries for the next visit. Celeste was further visited on 2nd May 2021 by the FACT team. Celeste reported ongoing thoughts of the tv

hearing and seeking what she was doing. Celeste was compliant with her prescribed medication and was due a visit from family that day. It was noted in the agency records that Alfred was present in the house but not for the full appointment. The FACT team visited for a third time that week on 5th May 2021. Celeste reported at this consultation that her mood had been a little better. She had paranoid thoughts still about the tv and phone but was managing. The practitioner asked again whether Celeste had any concerns and it was noted in the records that it took a while for Celeste to decide how to answer because she responded no. It was also recorded that it appeared she had more she wanted to say but did not.

14.30 On 7th May 2021, Alfred discussed his medication for his mental health with a speciality doctor at Hertfordshire Partnership University NHS Foundation Trust. Alfred was of the view that his mental health medication was causing gastrointestinal problems. He was informed that this was unlikely but could consider reducing and coming off the medication if need be. The same conversation took place between Alfred and his GP Practice on the same day.

14.31 Three days later on 10th May 2021, Celeste was visited again by the FACT team. On this occasion Celeste reported feeling very unmotivated and spoke at length how this wasn't normal to her and she didn't like feeling that way. It was reported that otherwise she seemed settled in mood and reported no self-harm or suicidal thoughts. The same day Alfred contacted the Hertfordshire Partnership University NHS Foundation Trust again reporting that he felt his physical health needs were attributed to his medication. He also advised that he had concerns for the upkeep of the mortgage on his property as well as his wife's mental health stress and he therefore wanted a particular medication. An email detailing this request was sent to the specialty doctor within the Trust the same day. The following day, Celeste received a visit from the FACT team but she was not in and Alfred informed the practitioner that she had gone for her blood test at the drop in clinic.

14.32 On 16th May 2021, Alfred attended the Emergency department at Lister Hospital, part of East and North Hertfordshire NHS Trust with complaints of abdominal pain and weight loss. He reported that he had a history of misusing alcohol, would binge drink for a few days then have some days off. Alfred was provided with an outpatient gastroenterology appointment for two days later for ongoing investigations in view of his medical symptoms. This attendance was communicated back to the GP Practice the same day. Two days after this, Celeste spoke to a member of the FACT team over the phone and advised that she had had a panic attack. It was agreed that she would discuss this with the worker a few days later when they met in person. Otherwise Celeste reported she was ok, she had walked the dog and seen her sister earlier that day. The same day as this phone call Alfred attended an outpatient clinic at the Lister hospital , he reported that he had cut down on some of his medication and felt that his mental health is not related to his abdominal pain. Alfred also added that he had stopped smoking cannabis about one year prior. It was noted also within the agency records that Alfred had been repeatedly ringing the gastroenterology secretaires which they were finding distressing. It was agreed that he would be seen face to face the following week for a full review.

14.33 There was an agency record on 24th May 2021 that Celeste did not attend the clinic as agreed. Hertfordshire Partnership University NHS Foundation Trust attempted to make contact with her on several occasion with no success. They contacted Alfred who advised that Celeste was away with her parents for a week as she was getting very stressed. The health practitioner reminded Alfred that the blood test at the clinic is protocol for the medication that Celeste takes and Alfred responded 'you need to give her a break as she is not well'. Alfred advised that she had plenty of medication and would be fine. The practitioner expressed concern by this as there shouldn't be a surplus of medication, this is supported by the policy and that suspicion of this, dependent on the individual should be risk assessed and managed by seeking to obtain any surplus medication. It was noted in the agency records that there was concern that Alfred did not understand the severity of managing this medication in terms of regular blood tests and not keeping a surplus at home. The missed appointment was also shared with the multi disciplinary team.

14.34 Alfred was seen face to face in an outpatient appointment at QEII hospital on 25th May 2021 and he reported that he had stopped taking his antipsychotic medication two weeks prior because he felt that these were causing his abdominal pain, and that he was still under the care of the Hertfordshire Partnership University NHS Foundation Trust. It was noted in the records that Alfred admitted he had recent weight loss of 4 stone. A decision was made that Alfred should have a CT scan and x-ray to look for any evidence that would explain his abdominal pain. Alfred was encouraged to discuss his medication for his mental health with the Consultant Psychiatrist. The summary of this appointment was also shared with the GP Practice.

14.35 On 1st June 2021, Celeste attended the clinic for monitoring. It was noted that she appeared anxious and fidgety. She advised that she was compliant with her medication and was reminded that any surplus medication should be returned. Celeste was confused by this as she added that she had enough medication to last her until next blood test. It was agreed that Celeste would attend Roseanne House to drop off the medication or that someone would collect from her home address. This was done 2 days later on 3rd June 2021. The same day Celeste had a telephone consultation with the GP Practice, this was a courtesy call from the practice to see how she was. Celeste reported that she did not have any thoughts of self harm and that her family were a protective factor.

14.36 Celeste was seen with her mother at the clinic on 9th June 2021. Celeste reported feeling anxious and fearful, she believed that she was going to come to some harm. Celeste stated that she felt like she was being watched and that there were cameras installed in the neighbouring trees and her movements were being monitored. Celeste stated that she had been using alcohol and diazepam periodically to manage her distress and anxiety. Her issues with OCD were not causing her problems at present. It was agreed and concluded at the consultation that she required more support and closer monitoring as her mental health was not improving and she was feeling distressed. The following day the FACT team discussed the latest position of Celeste's health and it was agreed that medication would now be held by Rosanne house and dispensed daily with support.

14.37 On 10th June 2021, Alfred spoke with his GP Practice about his abdominal pain which was still ongoing. It was agreed that it was best left with the specialist team at East and North Hertfordshire NHS Trust to manage Alfred's symptoms.

14.38 From 11th June 2021, Celeste's daily visits from the FACT team began. Celeste was seen with Alfred at the consultation and it was agreed that the FACT team would supervise the morning medication and Alfred would supervise the evening medication. It was noted by Celeste that she was still experiencing paranoia. She had further visits that week on 12th, 14th and 15th June 2021, nothing was reported of any significance other than she was not feeling well and that workers struggled to build a rapport. On 15th June 2021, Alfred had a telephone clinic appointment with the gastro team at East and North Hertfordshire NHS Trust, where it was discussed with Alfred that his abdominal pain and anxiety may be increasing due to pain perception. A further medication was added to Alfred's care plan to support with this. This same day a further sick note was authorised for Alfred. This was communicated back to the GP Practice.

14.39 The FACT team daily visits continued the next week, Celeste was visited by this team to supervise her medication and support her on 16th,17th, 18th, 19th and 22nd June 2021. Celeste reported feeling better on 16th, it was noted she appeared slightly anxious on the 17th but with no immediate concerns and she added that her husband was unwell so was in bed at the time of the visit. On the 18th June, it was noted in the agency records that she appeared slightly anxious in mood but Celeste reported feeling better in mood. Celeste advised that taking the medication regularly in the morning at the same time she felt was helping. This was supported again on 22nd June 2021. When Celeste was visited on 23rd June 2021 by the same team, she said that she was feeling a little better although Alfred was due to go to hospital the next day for an operation. On 24th June 2021, it was recorded that Celeste appeared calm in manner however tired.

14.40 On 24th June 2021, Alfred attended the hospital in order that his colon could be examined to explore his abdominal pain. It was recorded within the notes that Alfred was rolling around on the trolley expressing severe pain. He was advised that the procedure would be impossible if he was in that much discomfort and would need to be taken to A&E. Alfred's discomfort eased and procedure went ahead with no further issues. He was advised to return to the clinic on 19th August 2021.

14.41 Celeste continued to receive visits from the FACT team on 25th, 26 and 27th June 2021. All visits were recorded as Celeste managing her medication and mood. On 26th June 2021 Alfred asked to speak with the health practitioner. He spoke of his physical health problems and how he was concerned about Celeste and if anything happened to him. Reassurance was given to him and it was explained that the team would support Celeste if required. There was no evidence within the records that a carer contingency plan was discussed with either Celeste or Alfred.

14.42 As what was normal practice for this period, Celeste received a visit from the FACT team on 27th June 2021 and there were no risks or issues identified. Later the same day, Alfred was taken into the Lister Hospital Emergency Department with reduced consciousness and unable to maintain his own airway. The cause of the unconsciousness

was not known at the time, however Celeste reported to the health practitioners that he had recently complained of severe abdominal pain. She called an ambulance because she could not wake him after his nap, it was reported by Celeste's family as part of this review that it was their initial thoughts that he had overdone it with the sleeping pills as he used to say that the only time he was not in physical pain was when he was sleeping. Alfred's family arrived at the hospital and reported that Alfred had stated 'he had had enough' and 'only staying alive for his wife and mother'. The Medical team were also informed that Alfred had stopped taking his antipsychotic drugs recently. Alfred was transferred to Intensive Care later that day. This was communicated to this GP Practice for information. Alfred's family and Celeste were in regular contact with the hospital for updates. A CT scan on 28th June 2021 noted that his abdomen was clear therefore the doctors wondered whether his symptoms were akin to alcohol withdrawal and used medications to manage this. Alfred's family advocated that he had not been drinking recently, but had been experiencing a low mood and anxious due to ongoing medical issues. Celeste was also seen on 28th June 2021 in clinic for her medication.

14.43 The following day Celeste had a conversation with her Consultant Psychiatrist. Celeste reported that she had found Alfred collapsed a couple of days ago and that he was in hospital. She advised that Alfred had a chest infection and a collapsed lung. She said that she was worried about him but had the support of her mother who was staying with her. She also advised during this consultation that she felt more settled with having the support of the FACT team, less paranoid and more comfortable taking her current combination of medication. Celeste also reported that she was cutting down her alcohol intake and is restricting it to weekends. Current risk of harm to self or others was recorded as low. Later this day, Alfred was awake, extubated and sat out in a chair. He was complaining of a burning pain in his abdomen, therefore medications were restarted. Alfred's family advised once again that Alfred had been experiencing anxiety to nursing staff who noted that they would try to get him to open up. On 1st July 2021 during Alfred's admission, he reported to staff that he felt ashamed for having taken an overdose of his pain medication and this was with the intention to 'end his pain'.

14.44 Celeste continued to have contact, mostly visits, from the FACT team most days; 30th June, 1st, 2nd, 3rd, and 4th July 2021. At each visit Celeste reported on progress of how Alfred was in hospital and that she was finding it hard not being able to visit him due to the Covid 19 pandemic. It was recorded within the notes that although there were no new risks, it was felt that Celeste was not disclosing how she was really feeling and appeared flat in mood in particular on 4th July 2021. On 5th July 2021 Alfred spoke with a community nurse from Hertfordshire Partnership University NHS Foundation Trust over the phone whilst still in hospital. The purpose of the call was to discuss the reason for his admission into hospital being a suspected overdose and why he refused to engage with mental health liaison team at the acute hospital where he was staying. Alfred explained that he was experiencing significant pain and it was agreed that upon discharge Alfred would inform the Adult Community Mental Health Service. Celeste continued to be seen by the FACT team on 6th, 7th and 8th July 2021. Celeste requested at one of these to have her medication changed and another she mentioned that Alfred might be discharged and it was noted in the agency records that she appeared worried.

14.45 Alfred was discharged home from hospital on 8th July 2021 with the plan that the GP Practice would follow up with him on pain relief and the Community Mental Health Team from Hertfordshire Partnership University NHS Foundation Trust would contact Alfred to discuss treatment and medication. This was all communicated to the GP Practice the same day, describing his admission as an overdose.

14.46 On 10th July 2021, Celeste was visited by the FACT team and it was reported in the notes that her mood remained low. She denied any self harm thoughts and advised that she was happy to have Alfred home. The following day, the FACT team made a further visit to Celeste as planned. At this consultation, Alfred reported to the FACT health worker that Celeste had not been doing too well and that she had been having racing thoughts in the evenings and struggling with that. Alfred requested that Celeste see her Consultant Psychiatrist. There was no carers assessment discussed or offered at this time however the request was actioned. The same day Celeste's mother made contact with Hertfordshire Partnership University NHS Foundation Trust to also voice her concerns about Celeste's mental health. She explained that she was concerned that Celeste's mental health had deteriorated. Celeste's mother asked whether the care team would be available to discuss the issues further and her concerns about Celeste. She also reported that Celeste was safe with Alfred at home and that her family are able to keep her safe. It was advised that she could call back the next day and in the meantime could call the helpline for further support if required. The next day, Celeste's mother called the Adult Community Mental Health Team to report that her daughter was feeling suicidal and that Celeste would not speak to anyone on the phone and therefore Celeste's mother advocated that a visit was needed. Later that day Celeste was visited by the FACT team, it was recorded within the agency notes that she remained guarded and appeared not to want to talk. Alfred was home and Celeste reported that this was a relief. It was also noted that Celeste was encouraged to share how she was feeling but she didn't and appeared low in mood throughout the visit.

14.47 The following day on 13th July 2021, Celeste received a further visit from the FACT team, her presentation was very similar once again; remained guarded and did not want to talk. Celeste requested at this consultation to speak with her Consultant Psychiatrist about her medication. It was noted in the agency records that there was no assurance that she was fully compliant with her medication. The same day Alfred was spoken to by the mental health nurse at his GP Practice. Alfred reported that he still wasn't feeling great. He said that he was back on some medication which was helping slightly and he was now under Roseanne House and had an appointment in September but could phone earlier if needed. He did not report any deliberate self-harm or suicide and is hopeful that his mood will continue to improve. Celeste was visited the following day by the FACT team, on 14th July 2021, where she reported feeling a lot better than the past few days and was supported with medication as usual practice.

14.48 The following day Celeste received another visit from the FACT team at home. Celeste was crying when the visit took place, she reported that she had received a distressing text from her sister. Alfred advised the worker that she had concerns for Celeste's mental state expressing that they have been asking for a review. Celeste shared that she thinks others can hear her thoughts and therefore is feeling paranoid. Celeste took her morning medication under supervision. However it became clear that she had not taken

her medication for the previous night. A call was made to the Consultant Psychiatrist and she attended Rosanne House later that same day to see them. She attended with her mother and expressed that she was feeling worse with repetitive intrusive thoughts of an aggressive nature which she was trying to resist but couldn't stop. She described her paranoia in more detail and that there were stressors in the context of her worries about Alfred's physical ill health. Celeste and the Consultant Psychiatrist discussed her medication and this was reviewed and changed. The following day at her visit with the FACT team, she reported feeling reassured after seeing the Consultant Psychiatrist. The following 4 days she continued to present and advise during these visits that she felt brighter and well. Alfred expressed to one of the FACT team health practitioners on 21st July 2021 that he was still concerned for Celeste and would like some of her medication increased, this suggestion was made to the Consultant Psychiatrist by the FACT team and they also agreed- this was with affect from the following day.

14.49 Celeste continued to be visited by the FACT team each day the following week, each time Celeste reported no concerns and felt well with no risks of self—harm or suicide. It was suggested on 27th July that her daily visits might reduce now that she was feeling better. Celeste agreed to this suggestion. Also during this week, Alfred's GP Practice called him to see how he was following a call into the Practice from Alfred earlier that morning. Alfred expressed that he was still experiencing abdominal pain and medications were discussed. The GP confirmed that they would await an update from the gastroenterology team first.

14.50 Although Celeste's visits from the FACT team continued to go well. On 30th July 2021 when she was visited, she reported difficulties with mood and motivation. She stated that her intrusive thoughts were preventing her from doing anything. She advised that Alfred was going to the shops and she wished she could, Alfred was present and it was reported that he was being supportive. A discussion took place in terms of what was preventing her, she said that Alfred and her family were encouraging her to go out. She also expressed how appreciative she felt for some flowers she received that day from her sister in law as a way of making her feel better. Celeste's visits from the FACT team continued on 31st July and 2nd August 2021. However on 3rd August 2021, she did not receive a visit from the FACT team, and became anxious, therefore it was recorded within agency records that her mother contacted Hertfordshire Partnership University NHS Foundation Trust to update the team and ask when Celeste would expect a visit and her medication. The Duty Manager advised that further supplies were required from the pharmacy and therefore it would be delivered later that day.

14.51 The following day, Celeste was visited by the FACT team and Alfred was also present. Alfred expressed during this visit frustration that Celeste had not received a FACT visit the day before on 3rd August 2021 nor her medication and that this left her feeling anxious and unsettled. The FACT worker apologised and advised that she would feedback, that daily visits are still needed. The FACT workers also under the Consultant Psychiatrist's support left additional medication for the next day in order to ensure that they were not left without any. Alfred also reported as part of this visit of Celeste's alcohol consumption and that she was still drinking fairly frequently. Celeste was reminded by the FACT workers that this could contradict the medication that she was taking and therefore that she should consider reducing this. Celeste responded advising that she does plan to reduce her alcohol

consumption because it also impacts her paranoia, suicidal ideation and intrusive thoughts. Celeste was visited again the next day, despite medication already having been delivered. It was reported that her motivation was still poor but she was going to try and leave the house that day to take the dog for a walk with Alfred. The following day, Alfred called into the Adult Community Mental Health Service and spoke with Celeste's Consultant Psychiatrist via phone in relation to Celeste's mental health Alfred reported that Celeste had been better but later tearful and distressed and Alfred asked on her behalf whether some of the medication could be increased. This was agreed. Celeste reported to be in more positive spirits the following day because although she didn't feel well she was hopeful that the increase would help. This position continued until 13th August 2021.

14.52 On 13th August 2021, Celeste was visited again by the FACT team, it was reported that she felt low in mood and still worried about the TV sometimes. It was noted that she presented as guarded. When the FACT worker asked how Alfred was, she shrugged and said ok and that he was going out with friends. No further questions were asked and no risks or issues raised. After this time on 17th August and 22nd August 2021, when Celeste was seen by the FACT team, Celeste expressed that she had managed to go out with Alfred and felt brighter in mood. This was positively encouraged by the FACT worker.

14.53 On 23rd August 2021, Celeste was due to attend the clinic and as part of this visit she met with a Consultant Psychiatrist because she reported feeling anxious and distressed as a result of the intrusive thoughts and paranoia. Her paranoia related to her feeling as though she was being watched and people around her knowing what she was thinking. It was recorded that Celeste admitted to drinking more than normal (5 bottles of wine weekly) but will tackle this when her mental state is stabilised. She reported that Alfred was better and that they had celebrated his birthday together. She also advised that she was finding the daily visits from the FACT team reassuring and supportive. It was reported at her next FACT visit which was on 25th August 2021 that she had spent a few days staying with her mother for a change of scenery which had helped. She felt her mood improved and paranoia decreased when she stayed away from home. She also did report at this visit that she had had a bad dream which had escalated her paranoia. When asked about it she did not want to discuss her dream but needed reassurance that people couldn't read minds or dreams. On the same day Alfred spoke with his GP Practice as he had ran out of some medication for his abdominal pain. He advocated to the GP Practice that he wanted to be referred to the chronic pain clinic rather than await the outcome from gastroenterology because he was in a lot of pain. A referral to the chronic pain clinic was made on 27th August 2021- two days later. Also on this date, Alfred reported to a specialty doctor that his mood was low. It was agreed that he could increase his medication. Celeste also received a visit from the FACT team where she advised that she was still suffering with paranoid thoughts but appeared to have a little more insight.

14.54 Celeste continued to have visits from the FACT team that following week, advising that she was again going to stay with her mother on 30th August 2021 evening for a change of scenery. On 1st September 2021 Celeste reported to the FACT worker as part of the visit that she had had a bad dream that night and was feeling preoccupied with the thought that people could read her mind. She continued to report during that week at her FACT visits that her mood was up and down. On 6th September 2021, Alfred made contact with his GP

Practice again in relation to his medication for abdominal pain, this was changed and a new prescription was arranged.

14.55 On 8th September 2021, Alfred spoke with a specialty doctor from the mental health trust about his low mood and experiencing intrusive thoughts when anxious. He reported poor sleep and an earlier overdose in hospital had been a 'cry for help'. He said that he was in physical pain and his GP had been exploring what the cause was. He advised that at that time, when asked, he did not have any suicidal ideation or self-harm/plans to harm others, as a result of his concerns his medication was altered. The role of carer to Celeste was not discussed, although Alfred did share with the doctor that his wife suffers with mental health problems and he has been worried about her. This information was shared with the GP Practice the same day.

14.56 Two days later on 10th September 2021, Celeste was visited by the FACT team, it was noted in the agency records that she appeared low in mood. When she was asked, she responded saying that she was feeling very down. Celeste also advised that Alfred was not very well again which was also affecting her mood and was very worrying for her. She said that he was going to see the doctors soon. She appeared to have little motivation to go out that day and said she planned to have a day in bed. She was encouraged to go out for a walk. Three days later, on 13th September 2021 she was visited by the FACT team and advised that she planned to see her mother that day and stay overnight. She was then seen again by the FACT team on 15th September 2021, following her time with her mother which she said helped her mood and motivation when she was there. She said that she felt preoccupied by the intrusive thoughts when staying at her mums.

14.57 In mid September 2021, Alfred rang Rosanne House to speak with a Psychiatrist. A specialty doctor returned his call the following day, however it went to voicemail and a message was left. Later that same day, Alfred contacted his GP Practice advising that he was still in a lot of pain, particularly when he ate anything. A medication review was undertaken and he was prescribed something new to try whilst he waited for contact from the pain clinic and a follow up in October 2021 with the gastroenterology.

14.58 The following day, Celeste received her visit as usual from the FACT team. She appeared low in mood according to the FACT worker and records. Celeste reported that her husband was ok but is quite tired a lot of the time. Later the same day, Alfred was found laying face down on the floor in a public car park in their home town. 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.

14.59 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 the 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.

14.60 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.

15. Overview

15.1 The agencies listed in Section 8 were invited to attend the Panel meeting to discuss their involvement:

15.1.1 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.

15.1.2 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.

15.1.3 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.

15.1.4 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.

15.2 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.

15.3 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).

16. Analysis

16.1 The Panel has considered the individual management reviews (IMRs), through the viewpoints of both Celeste and Alfred, to ascertain if the agencies' contacts were appropriate and whether they acted in accordance with their set procedures and guidelines. Where they have not done so, the panel has discussed whether the lessons have been identified and appropriately actioned.

16.2 The authors of the IMRs have followed the Review's Terms of Reference and addressed the points within it. The agencies undertook the IMRs in an honest, thorough and transparent fashion, ascertaining information from a number of sources. The following is the Review Panel's view on the appropriateness of the intervention undertaken by each agency.

East and North Hertfordshire NHS Trust

16.3 As per paragraph 15.1.4 Celeste only had one documented episode with this organisation during the timeline of this review. This was on 27th June 2020 when Celeste attended one of the Urgent Care Centres in Hertfordshire with a head injury/laceration to her forehead which she reported was as a result of a fall whilst intoxicated. Alfred also attended the hospital with Celeste. However following Covid guidance and Trust policy at the time, he was asked to wait outside. Both the Triage Nurse and Emergency Nurse Practitioner managing Celeste's care noticed that Celeste presented as 'nervous, anxious' and 'was looking over her shoulder as to where her husband went'. As a result of these behaviours and additional bruising identified on Celeste, health professionals queried the cause of the bruising and undertook a more comprehensive examination of her upper body. Celeste was also asked by the same practitioners whether she was in an abusive relationship. Although Celeste denied this, the nursing staff continued to voice their concerns, seek advice from the safeguarding team and complete a safeguarding adults referral. The organisation confirmed as part of the review that this was all in accordance with Trust policy and pathway 'Responding to a disclosure/high suspicion of domestic abuse'. The Panel upheld this as good practice, that possible signs of domestic abuse were identified and professionally curious questions were asked by the practitioners to ascertain further information. To note, the family advised as part of this review that Celeste had told

her family she had been drinking with Alfred in 'his man cave' at the bottom of the garden and had tripped down the stairs when coming out.

16.4 Timeliness of the safeguarding adults referral was also upheld as being within the requirements of the policy. The referral was completed with accuracy and submitted to the Trust's Safeguarding Team on the same day. The referral was assessed by the Adult Safeguarding Team on the next working day and submitted to Social Care that same day. Unfortunately, it is unknown what the outcome of this referral was because there is no record of receipt held by the Adult Social care team which is hosted by Hertfordshire Partnership University NHS Foundation Trust.

16.5 It was explored within the IMR and Review Panel whether a referral could have been made to the IDVA service or Celeste signposted to local specialist domestic abuse services. This organisation confirmed that they would not have been able to refer Celeste to the IDVA service because she denied domestic abuse and did not consent to support from this service. The Panel discussed consent and concluded that where an individual is at high risk of domestic abuse a referral may be made without consent, however in this instance a thorough risk assessment had not been undertaken with Celeste owing to her denial of being in an abusive relationship. This organisation did recognise that although a referral to the IDVA service could not be undertaken, Celeste could have been provided with further information about domestic abuse charities in order that she could have accessed independent support at another time if required. The Panel agreed that this could have been a missed opportunity and a learning point for this organisation.

16.6 The Panel discussed, following the receipt of this IMR, how MARAC referrals are completed, processed and managed in Hertfordshire. This discussion arose because based on the concerns of the nursing staff as a result of Celeste's attendance at the Urgent Care Centre, it could have been suggested that a referral to MARAC was actioned based on professional judgement. However as a domestic abuse risk assessment was not undertaken, and there was limited information in addition to Celeste's denial of any abuse then this organisation felt that it would not have met the threshold for an accepted referral into MARAC therefore one was not completed. Instead action was taken to submit a Safeguarding Adults referral with Celeste's consent. MARAC thresholds are discussed further in section 17. The Panel debated whether a referral to Safeguarding Adults was the right decision and concluded that it was. The rationale being similar to that of this organisation, that by sharing the information with the local authority adult safeguarding team some triangulate of information and further risk assessment could be undertaken. It was unfortunate that no further action or outcome came of this referral. However the Panel were assured that since this time, a new local authority safeguarding referral portal exists which enables referrals to be tracked more robustly. This service is also still held by Hertfordshire Partnership University NHS Foundation Trust.

16.7 This Acute Trust also had some significant contact with Alfred as part of the timeline. This has not been explored and analysed in detail because the focus of this Domestic Homicide Review is Celeste. However, there was one main conclusions borne out of the Panel discussions and the IMR provided by this organisation, was that following Alfred's contacts with either the Emergency Department or Outpatient teams- a wider assessment

of his relationship with alcohol was not explored or discussed with him as much as it could have been. By exploring his use of alcohol, as a coping mechanism, may have enabled further information to be ascertained about his circumstances; his caring responsibilities for Celeste and his own wellbeing. A recommendation was agreed that the Trust should undertake some awareness raising with clinicians so that they can identify problematic drinking and ensure adequate support is offered to those individuals who require it.

16.8 In conclusion, this organisation had limited contact with Celeste, however following the identification of some potential signs of domestic abuse, this was further explored with her which was upheld as good practice. Information was shared with other relevant agencies including the GP Practice, so that follow up discussions could take place if required. This organisation highlighted three recommendations see section 19 for more information.

Hertfordshire and West Essex Integrated Care Board

16.9 This organisation worked closely with both GP Practices where Celeste and Alfred were registered to collate the information required for this review. Both GP Practices thoroughly engaged with this process and attended Panel meetings to present their reflections in an IMR presentation which was extremely valuable. Both Celeste and Alfred were registered at different GP Practices, it is unknown why this was the case and did hinder and limit what information was known by which GP Practice, particularly given how they both 'cared' for one another as they both had their own physical and/or mental health diagnoses. It was noted by the Integrated Care Board that owing to patient choice, previous addresses and patient lists this is becoming more frequent that not all members of the same household are registered at the same GP Practice.

16.10 Firstly, Celeste was registered with Hall Grove GP Practice in Hertfordshire and had been since 1988. It was noted within this IMR that Celeste's appointments and consultations were with many different GPs working at the Practice throughout the years she was registered there. Celeste had very limited contact with her GP Practice over the period of this review. It was thought by the Panel and family members involved in this review that Celeste would contact Hertfordshire Partnership University NHS Foundation Trust for support when she needed it. Celeste's main contact with the GP Practice during the timeframe of this review was at the start of June 2021 when she received a courtesy call from the GP Practice in relation to an annual health check. The GP Practice confirmed to the Panel that they offer all patients with mental health concerns annual Mental Health and Physical checks. The Panel praised the GP Practice for doing this and highlighted it as an example of best practice.

16.11 Hall Grove GP Practice advised within their IMR that they did not see any signs or behaviours suggestive of domestic abuse and therefore they did not offer any interventions. The Practice recognised that some of the consultations being undertaken during this time were not face and face and usually via phone which could hinder identifying non-verbal cues. Nevertheless, the Panel confirmed that given there was little rapport and contact that this Practice had with Celeste it was unlikely that any domestic abuse indicators were missed. The Panel sought assurances from this GP Practice on how they train and support their staff to identify the signs of domestic abuse and coercive control. The Practice

confirmed that they do have a Domestic Abuse Policy which is kept up to date and that training is undertaken by staff within the Practice using an online platform, however additional events are often hosted by the Integrated Care Board or Local Medical Committee. They also confirmed that they have safeguarding meetings every 2 months to discuss vulnerable children and adults. The Integrated Care Board supported this advising that there is an ongoing programme of work underway where a Domestic Abuse Toolkit has been developed for Primary Care and is being embedded by the Integrated Care Board Safeguarding team with close support of the Named GPs.

16.12 The Panel also explored with the GP Practice the role of 'carer' and whether in any of Celeste's presentations at the Practice she had shared anything about her husband and his mental health and physical health concerns. The GP Practice confirmed that she was not identified as a carer and little to no information had been shared about her home life. The Panel also explored with the GP Practice the challenges with identifying an individual as a carer to someone who is not registered at the same GP Practice. This is further explored in later sections of this report. However, for GP Practices it was felt by the Panel and agreed that should information come to light that a patient was also caring for another individual whether they be registered at the same Practice or not that professional curiosity would feature. In order that the wellbeing of the patient and their needs as a carer were understood, addressed and signposted to support when required. 'Caring' being the definition of supporting the individual with their medication as an example, and any other everyday care and support needs. It was recognised that the couple were doing this for one another because they were in a relationship and were one another's partner. However, the technical definition of 'caring' was regarded by the Panel to be helpful in identifying those in that role to ascertain further support and ensure their health and support needs were being met.

16.13 Another area which was highlighted as good practice was the communication from Hertfordshire Partnership University NHS Foundation Trust to the GP Practice. During the IMR presentation from the Practice, it was recognised that there were regular updates shared by the Trust to the GP Practice for Celeste's care coordination. On occasion the updates were a little delayed, however accurate and factual. Communication between Primary Care and Secondary Care is further explored in Section 18.

16.14 There was a learning point highlighted as part of this IMR, this was in relation to the information received by the GP Practice of Celeste's attendance at the Urgent Care Centre with a head injury and that a safeguarding adults referral had been made to Adult Social Care. The GP Practice reflected that this could have initiated a follow up courtesy call to Celeste to see how she was given that it was known to the Practice that she had a mental health diagnosis, was under the care of the local Mental Health Trust and deemed to be vulnerable. A further Panel conversation took place in relation to how 'vulnerability' is identified, the GP Practice advised that this is determined on a case-by-case basis and what information is known about a patient and their circumstances or difficulties. It was also supported that a recording of the presentation at the Urgent Care Centre and safeguarding adults referral should have resulted in a safeguarding alert being added to her electronic patient record for any future patient consultations. The Panel supported the

recommendation on the basis that the GP Practice are usually the only health agency to receive and have recorded all relevant contacts about a patient's care.

16.15 As has already been mentioned Alfred was registered with a different GP Practice and had been for most of his life. During the time period for this review he contacted the Practice frequently- sometimes multiple times in one week. His contacts with the GP Practice were sometimes with concerns for his mental health; mood and behaviours, and other times in relation to his physical health for example abdominal pain. It was helpful to the Panel to receive an IMR from his GP Practice in considering how the coordination of Alfred's care for both physical and mental health was managed and information shared. Within the IMR, the GP Practice advised that their view was that Alfred had longstanding concerns about his health and was particularly fixed on the belief that he had undiagnosed gastrointestinal cancer. It was also valuable to receive this reflective report from his GP Practice because although Alfred did not identify himself as a 'carer' for Celeste, and nor did Celeste's family members who contributed to the review. It was a key line of enquiry to consider how Alfred managed his own health alongside supporting his wife Celeste who had a significant mental health diagnosis.

16.16 It was recorded within the GP Practice records that Alfred did disclose that he was having some thoughts of harming himself, his wife and dog. The Panel discussed with Alfred's GP Practice how they risk managed these disclosures. The GP Practice advised that despite Alfred's request for face to face appointments, some of his patient consultations were undertaken via phone which did not always enable clinicians to pick up on some of the non-verbal cues and have more detailed discussions about his ideations relating to self-harm and harm to others. The Practice acknowledged that there was no consistent exploration with Alfred about the risk to others, and therefore a recommendation was agreed and supported by the Panel. This was that when patients disclose any harm to self or others that enquiries are made to better understand the risk, signpost or share information with those who can adequately risk assess like the local Mental Health Trust. The GP Practice also reflected that owing to the frequency and volume of contacts Alfred had with the Practice and Hertfordshire Partnership University NHS Foundation Trust it was challenging to have a clear understanding of all that was going on for him at any one time. The Practice also advised the Panel that they may have been falsely assured by the frequency and volume of contacts. This was because he was proactive in seeking help that the level of risk was not escalating and he was just accessing the help he required, therefore his needs were being met.

16.17 Similarly to the above point, Alfred's GP Practice did also not identify Alfred as a 'carer' for Celeste and therefore the Panel felt there was a missed opportunity when Alfred disclosed his thoughts of harming others that his relationship and support for his wife was not considered. The Panel concluded that had this been explored, the GP Practice may have identified him as a 'carer' and signposted him for further support. A recommendation was agreed by the Panel that the GP Practice needed to raise awareness of 'caring roles' so that even when patients do not identify it, referrals and signposting can be made to best support those individuals. Again, it is recognised and heard by Celeste's family that neither Celeste or Alfred saw themselves as a 'carer' only a loving, caring and supportive partner. However

in Section 18 this is explored in more detail, noting the technicalities of a 'carer' and access to additional support, help and guidance.

16.18 The Panel also sought assurances from this GP Practice in relation to domestic abuse awareness, training and policy. This Practice advised that the Hertfordshire and West Essex Integrated Care Board had produced a domestic abuse policy toolkit which they were intending to use to create a stand-alone document in line with the learning from this case. Emphasising the more subtle signs and indicators of coercive control. The Practice also confirmed that it had domestic abuse training in place for staff within the team. In addition the Practice added that they also have in place a nominated administrator who is responsible for domestic abuse; they receive and share any related paperwork which comes from the police or any other agency and regularly meet with the Lead GPs for Adult and Child Safeguarding within the team to discuss cases and provide supervision. The Panel upheld this as good practice.

16.19 In analysing both reports, the Panel felt that it was clear there were and would still be barriers today in supporting couples who were and are registered at different practices because of patient confidentiality and information known. However in this instance, had further information been gleaned by both GP Practices about their patients' 'caring' roles for their partners, then further support could have been offered to Celeste and Alfred together and separately which may have in turn enabled the sharing of information between GP Practices via other agencies.

Hertfordshire Partnership University NHS Foundation Trust

16.20 Celeste was well known to, and under the care of, secondary mental health services within the Hertfordshire Partnership University NHS Foundation Trust up until the time of her death. She had first contact with mental health services in her 20s. She was hospitalised with first episode psychosis follow a suicide attempt at the age of 26. Due to the nature of her schizophrenia, she was treated with Clozapine, a medication requiring monthly monitoring though blood tests to manage any potential risks associated with the medication. Celeste also experienced symptoms of Obsessive-Compulsive Disorder (OCD) for which she was on another type of medication. As a result of these medications she was reviewed regularly and had contact with this organisation frequently. There were also some concerns at various points with regards to her storing surplus medication which was another reason why Celeste began to have daily visits from this organisation to manage this risk. Assurances were sought from Hertfordshire Partnership University NHS Foundation Trust in relation to managing surplus medication, in particular Clozapine which was the medication prescribed to Celeste. Nevertheless, as reported by Celeste's family, she generally managed her diagnosis very well and engaged with services; attended relevant appointments and made contact to request support when needed. It was also noted by this organisation that Celeste's family and Celeste's mother in law were also very supportive of her and Celeste's mother in particular would often attend appointments with Celeste, and be actively involved in her care.

16.21 The Panel explored, following the receipt of the IMR, the frequency of review for Celeste's care that was undertaken by this organisation because there was regular contact

with Celeste. The Panel were assured that her care was regularly reviewed and often in conjunction with her mother and in response to any concerns that Alfred had raised. She was seen frequently by the FACT team for a good proportion of the timeframe of this review, including the morning of the incident in September 2021. It was also confirmed that the medication she was prescribed and monitored by was also all compliant with policy and healthcare guidelines. The Panel did highlight that both Celeste's mother and Alfred were also engaged with discussions about Celeste's care which was good practice, however neither were recognised or identified as a 'carer' or having a 'caring role' under the NHS definition. Celeste's mother advised that she would not define herself as one, because Celeste managed her illness extremely well. The Panel concluded that noting other significant individuals within a patient record would likely prompt broader discussions about the dynamics of relationships and the wellbeing and care of all those concerned. This may have enabled Alfred's care and wellbeing being more carefully reviewed had he been recognised by those supporting Celeste's care as a 'carer'. This is particularly given both Celeste and Alfred separately were being supported by the Adult Community Mental health Services team within this organisation. It was reported as part of this review that there was a noticeable lack of information sharing between Celeste and Alfred's care teams. It was also found that it appeared unclear whether the respective teams were aware of the increased support needs which may have been impacting on the stressors within the relationship. There was only one exception to this in April 2021 where Alfred overtly contacted Celeste's care team to advise on his and her position, however in this instance the organisation reported that it was still not confident that all staff working with Celeste or Alfred were aware that their respective other was being treated under the same team. Supporting couples who both have mental health concerns is further explored later in the report.

16.22 Similarly to the point above, the Panel were also assured that the risk of Celeste's mental health was also regularly reviewed. It was recognised by this organisation that various factors were having an impact on Celeste's ability to manage, hence daily visits were organised to offer support and to manage her medication. This organisation provided evidence within their documentation that supported this, advising that there was careful monitoring of identified risks around suicidal ideation and self neglect for Celeste. The Panel upheld this as good practice.

16.23 As has already been mentioned earlier in the report, there was evidence of good information sharing between this agency and Primary Care. However, given Celeste's diagnosis the Panel felt that she would have benefited from a Care Coordinator within the Mental Health Trust. Discussions took place at the Panel meeting about this, Hertfordshire Partnership University NHS Foundation Trust reported that Celeste's escalation in symptoms was during Covid when resources were diminished, and the delivery of care was changing each week as a result of infection prevention control guidance. The Trust, at the time, felt that the best response to Celeste's escalated symptoms was to undertake daily visits to her. It was unfortunate that there wasn't any consistency to these workers who may have been able to build a rapport with Celeste and/or Alfred upon attendance. This organisation spent time describing the Care Programme Approach to the Panel and how an individual care coordinator allocation would occur, following this discussion it was agreed that this was a

key learning point and that a recommendation and quality improvement programme would be undertaken across the Trust to change this. See section 19 for the recommendation.

16.24 Further to the above information, this organisation did not identify and were not made aware of any signs or suggestions that Celeste was in an abusive relationship. However, assurances were sought by the Panel on what training, policy and protocols are in place by this Mental health Trust to respond , had Celeste made any disclosures at any time. This organisation responded by advising that safeguarding training is statutory for all staff and is delivered monthly to ensure compliance. However that they could not provide a position on how much of this safeguarding training included domestic abuse because of the choice in modules. Following this review, this organisation advised that their intention would be to ensure that there is a way of monitoring compliance against the domestic abuse module. It was also added that they have a policy and other documents available to staff and patients to help raise awareness also. The Trust did acknowledge that more could be done to ensure that there are stronger links with other agencies on this subject, in particular Refuge; the commissioned domestic abuse specialist service provider in Hertfordshire.

16.25 There was also some learning for this organisation following the care provided to Alfred. However this was reviewed comprehensively as part of the terms of reference for the Mental Health Homicide Review. Please see this document for further information in relation to this learning.

17. Conclusions

17.1 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?

17.2 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.

17.3 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.

17.4 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.

18. Lessons to be learnt

Communication between health services

18.1 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.

18.2 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.

18.3 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

18.4 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.

18.5 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.

18.6 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.

18.7 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'

18.8 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.

18.9 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.

18.10 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.

18.11 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.

18.12 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

18.13 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.

18.14 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.

18.15 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

18.16 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.

18.17 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.

18.18 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

18.19 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.

18.20 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.

18.21 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.

18.22 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.

19. Recommendations

East and North Hertfordshire NHS Trust

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

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

19.3 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

19.4 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)

19.5 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

19.6 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

19.7 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.

19.8 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 …".

19.9 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.

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

19.11 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.

19.12 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

19.13 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

19.14 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.

Appendix A

Bibliography

Home Office. 2016. *'Revised Multi Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews'* [Online] [Accessed 18th April 2022]. Available from: https://www.gov.uk/government/collections/domestic-homicide-review

HM Government. 2015. *'Working Together to Safeguarding Children 2015'* [Online] [Accessed18th April 2022]. Available from: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/419595/Working_Together_to_Safeguard_Children.pdf

Home Office. 2012. '*Domestic Homicide Review Toolkit*' [Online]. [Accessed 18th April 2022] Available from: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/143782/dhr-report-guide.pdf

Local Government Association. 2022. 'Making Safeguarding Personal' [Online] [Accessed on 22nd February 2023] Available from: https://www.local.gov.uk/our-support/partners-care-and-health/care-and-health-improvement/safeguarding-resources/making-safeguarding-personal

National Institute for Health and Care Excellence. 2014. Domestic Violence and Abuse: How Services can respond effectively' [Online] [Accessed on 18th April 2022]. Available from: https://www.nice.org.uk/advice/lgb20/chapter/introduction

David Warren. 2015. 'Project to collate learning from the Domestic Homicide Review that have been completed across Avon and Somerset in order to improve the safety of individuals affected by domestic abuse' Final Report – Avon and Somerset Violence Against Women and Children Group. Available from: http://www.avonandsomerset-pMiss D.gov.uk/Document-LiMr Cary/Reference/DHRreview.pdf

Safe lives. 2019. 'Safe and Well: Mental Health and domestic abuse' [Online] [Accessed 9th March 2022] Available from: https://safelives.org.uk/sites/default/files/resources/Spotlight%207%20-%20Mental%20health%20and%20domestic%20abuse.pdf

Getting it right first time- safe lives

One front door- safe lives

Adass- ADASS, 2011. *Safeguarding Adults Advice Note,* London: ADASS.

Dinsdale et al (2019)

Pieces of legislation

Adoption and Children Act 2002

Crime and Disorder Act 1998

Domestic Violence, Crime and Victims Act 2004

Equalities Act 2010

Serious Crime Act 2015

Care Act 2014

Protection from Harrassment Act 2002

Appendix B

Confidentiality Statement

DOMESTIC HOMICIDE REVIEWS - Confidentiality Declaration

Domestic Homicide Reviews are conducted in accordance with Section 9 of the Domestic Violence, Crime and Victims Act 2004. The duty to undertake Domestic Homicide Reviews came into force on 13 April 2011.

The purpose of a DHR Panel is for agencies to share historical and current agency information known about the victim/perpetrator/family household members or known significant others; to share information about the events preceding the death of the victim; and to determine whether the statutory criteria for undertaking a Domestic Homicide Review has been met.

The purpose of a Domestic Homicide Review is to:

1. Establish what lessons are to be learned from the Domestic Homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims.

2. 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

3. Apply those lessons to service responses including changes to policies and procedures as appropriate

4. Prevent domestic violence homicide and improve service responses for all domestic violence victims and their children through improved intra and inter-agency working.

Information discussed by the agency representatives within the Domestic Homicide Review Panel is strictly confidential and must not be disclosed to third parties without the agreement of the partners of this meeting and in any case within accordance with Data Protection and relevant Information Sharing Agreements.

All agencies should ensure that the minutes are retained in a confidential and appropriately restricted manner. These minutes will aim to reflect that all individuals who are discussed at these meetings should be treated fairly, with respect and without improper discrimination. The responsibility to take appropriate actions rests with individual agencies; it is not transferred to the DHR Panel. The role of the Panel is to facilitate, monitor and evaluate effective information sharing to enable appropriate actions to be taken to increase public safety. It is the responsibility of that agency to complete their actions within the agreed time constraints.

In the event of a Serious Case Review or a Criminal Investigation the minutes from the Panel may be released to support that process. In signing this confidentially declaration you agree, with prior notification, for full disclosure of the minutes taken at this Panel.
The Chair of the Domestic Homicide Review Panel must adhere to the data protection clauses of their contract with Hertfordshire County Council.

Signed……

Date …….

Appendix C- Action Plan

Domestic Homicide Reviews in Hertfordshire: SMART Recommendation and Action Plan for the case of DHR Celeste

Recommendation (SMART goal)	Scope of recommendation (i.e. local or regional)	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target Date	Date of completion and Outcome
Increase visibility of IDVA services within QE2 urgent care setting	Local	1, Co-location of IDVAs at QE2. 2, Increase in leaflets and available resources for staff to provide patients with. 3, Creation and display of posters at QE2 4, Training & education to be provided to ENPs and staff at Urgent Care Centre	East and North Hertfordshire NHS Trust	**September 2023:** Refuge IDVAs are now co-located at QE2 and have space within clinical departments, increasing visibility and access to IDVA service for patients attending Urgent Care Centre. Emergency Nurse Practitioners have 3 monthly safeguarding supervision with the Safeguarding Team and sessions on domestic abuse have been offered and provided. IDVA have provided leaflets and signposting information to staff at QE2. IDVA service have provided training to staff to Urgent care centre clinical and non-clinical staff (Including reception staff) (November 2023).	November 2023	Completed, November 2022. IDVAs continue to provide support at QE2 as well as training if, and when necessary.
MARAC referral criteria to be disseminated to the	Local	MARAC criteria and professional judgement criteria to be	East and North	MARAC criteria recirculated to Safeguarding Team.	December 2022	Completed, December 2022.

safeguarding team, inclusive of referrals made based on professional judgement		disseminated to Safeguarding Team.	Hertfordshire NHS Trust			Increase in MARAC referrals from ENHT noted and Maternity Services now in attendance at MARACs.
Awareness raising to services in the Trust in relation to drug and alcohol services and referral criteria	Local	Increased presence of CGL (Change, Grow, Live) workers in the ED and Acute part of the hospital. CGL referral forms available on Safeguarding sections of Intranet. CGL contribution at "frequent attenders" meetings.	East and North Hertfordshire NHS Trust	CGL workers present through ED/Acute with daily rounds to support staff. Referral forms on Intranet – contact numbers are also available on wards. Attendance at "frequent attenders" meeting to discuss high risk cases/ high presentation rate to ensure a MDT approach to care and response (including MH/Safeguarding and ED).	September 2023	Completed, September 2022 – CGL continues to work closely with ED/ Acute part of the hospital.
Raise awareness of the need to include significant others when making enquiry regarding risk to self and then share that information/seek guidance and expert advice from Mental health services on how to manage.	Local	Discuss at practice meetings, include in professional supervision. ICB to disseminate learning.	Peartree Lane GP Practice and Across Primary Care	Discuss at practice meetings, include in professional supervision. ICB to disseminate learning.	01/02/2023 01/06/2023	DISCUSSED AT Peartree Surgery clinical meeting 31/1/22 with much learning. Consider the mental health of patients requiring opioid meds to help with chronic pain, always offer a holistic

						assessment in chronic pain. Clarification around contact numbers for CMHT Single Point Access and Crisis team.
Raising awareness for practice staff to identify patients who have a caring role, but may not identify themselves, as carers and make appropriate referrals.	Local	Discuss at practice meetings, include in professional supervision. ICB to disseminate learning.	Peartree Lane GP Practice and Across Primary Care	Discuss at practice meetings, include in professional supervision. ICB to disseminate learning.	01/03/2023 01/06/2023	Discussed at clinical meeting 31/1/22. We are now doing regular SMI checks which includes carer details and support network.
Raising 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.	Local	Consider the application of safeguarding alerts to electronic patient records.	Hall Grove GP Practice	Consider the application of safeguarding alerts to electronic patient records.	Beginning of 2022	All doctors are sent a task informing them of a safeguarding alert which is marked as urgent in the docman inbox.
A reflective learning session to be undertaken including ACMHS (Including LIT & FACT) and MHL team workers and inviting service user's GP to consider the learning points raised during	Local	Reflective Learning session to be held.	Hertfordshire Partnership University NHS Foundation Trust	Post Incident Debrief with all staff members involved in care of both service users.	August 2023 August 2023	Completed, August 2023. Completed, August 2023.

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.				Learning from case shared in monthly learning summary and disseminated through key internal forums.		Disseminated via Quality and Risk Meetings, local practice governance meetings and discussed at trust wide monthly learning event.
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	Local	The Clinical Risk Assessment and Management for individual Service Users policy V9 to be updated.	Hertfordshire Partnership University NHS Foundation Trust	Policy updated	Q.4 2021-22	Completed, December 2022. Policy has been updated and is available on the Trust Intranet (Hive).

factors must be considered …”.						
A Risk Assessment refresher session to be delivered to the E&SE ACMHS 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.	Local	Risk assessment refresher training to be delivered to ESE ACMHS.	Hertfordshire Partnership University NHS Foundation Trust	Risk assessment refresher training delivered.	Q.2 2022-23	Completed, September 2022. Refresher training was delivered to the team as part of a rolling programme delivered by the Clinical Director and medical lead for each service area.
The learning from this review to inform the development and delivery of risk simulation training to teams across the trust.	Local	Risk simulation scenario to be developed and delivered via simulation hub.	Hertfordshire Partnership University NHS Foundation Trust	Risk simulation scenario to be developed. Risk simulation scenario to be delivered.	Q.4 2021-22	Completed, January 2022. Case scenarios used in simulation suicide risk training for Trust staff and multi-agency partners incorporates collateral information gathering, dynamic and static risk, risk formulation, carer support and safety planning.

						Completed, January 2022. Welwyn ACMHS MDT staff attended the suicide risk simulation training pilot day.
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 this organisation is able to provide to support awareness raising of domestic abuse, signposting to support and knowledge.	Local	IDVA co-locations to be re-established across key ACMHS bases. HPFT Safeguarding Team to ensure DASH awareness and Basic Safety planning webinar is included in regular webinar schedule with input from Refuge.	Hertfordshire Partnership University NHS Foundation Trust	IDVA Co-locations restarted. Webinar requirements discussed with Refuge and scheduled for Q.3/4 2023 – 2024.	January 2024 August 2023	Ongoing. Completed and ongoing. 3x Basic Risk assessment and safety planning webinars delivered by Refuge in August 2023 and further webinars planned.
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	Local	Domestic Abuse resource kit to be developed for use by all staff. HPFT Webinar programme to include at least 1 Domestic Abuse webinar each month. Safeguarding training passport to include requirement for at least 1	Hertfordshire Partnership University NHS Foundation Trust	Resource Kit developed.	Q.3 2023	Completed, December 2023. Resource kit developed and a draft copy launched for consultation as part of 16 days of activism.

between domestic abuse and mental health.		core Domestic Abuse module within 3-yearly requirement.		Resource Kit cascaded to all staff via emails, HPFT newsletter and through relevant internal forums such as Quality and Risk Meetings. Webinar schedule for 2024/25 agreed and advertised via Electronic Staff Records. Training passport established on ESR systems	January 2024 February 2024 December 2024	Completed, January 2024. Completed, February 2024. Ongoing.
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.	Local	HPFT to present on Connected Lives framework to ICS Safeguarding Whole Network meeting.	Hertfordshire Partnership University NHS Foundation Trust	Presentation delivered.	Q.1 2023/24	Completed, presentation delivered.
The Partnership should collaborate, design and agree a communications plan which will share the following learning points from this review: • Strengthened understanding of	Local	Training plan to be reviewed against the main points of this recommendation: 1, Coordination of professionals' meeting 2, Knowledge and understanding of mental health and DA	Hertfordshire Domestic Abuse Partnership	The Strategic Partnership Team at Hertfordshire County Council is currently reviewing internal and external training offers as well as the most frequent requests received for training to identify gaps in training offer and will produce a training plan to address these gaps and involve the DA	June 2024	Ongoing, training and communications plan to be delivered to address gaps in knowledge and to increase

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		3, The impact of drug and alcohol on mental health and relationships 4, Benefits associated with being identified as having a 'caring role' to reduce the stigma		Partnership to help deliver these trainings.		knowledge and understanding of DA related issues.

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 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.						

Appendix D

List of agencies approached about this Domestic Homicide Review

- Hertfordshire Constabulary
- Hertfordshire County Council
- East and North Hertfordshire NHS Trust
- Refuge
- Hertfordshire Partnership University NHS Foundation Trust
- Hertfordshire and West Essex Integrated Care Board
- Hall Grove GP Practice
- Peartree Group GP Practice
- Welwyn Hatfield Borough Council
- Hertfordshire Probation
- Hertfordshire Community NHS Trust – safeguarding adult
- Adult Care Services
- Central London Community Health (CLCH)