North Somerset Safer Communities

Victim: Piotr

(DHR 5)

Year of Death April 2021

Author: Paul Northcott

Date the review report was completed: July 2022

Contents

Preface

This report has been anonymised to protect the identity of the relevant family members and all others involved in this review. The male victim in this review has been named Piotr. This name was chosen in accordance with his wife's wishes.

"We were a beautiful family" (Piotr's wife 2022)

I would like to begin this report by expressing my sincere sympathies, and that of the Review Panel to the family of Piotr, many of whom currently live in Poland. The death of Piotr was a tragic and unforeseen incident and having met with his wife it is apparent that it has a huge impact on all that knew the family. Piotr was a kind and considerate person who cared immensely for the welfare of his family. He and his wife worked hard to support and protect their son throughout his life.

Despite the deterioration in his sons mental health and his propensity to become verbally and physically abusive, his parents gave him their total support and had consistently tried to seek out the services that could treat him.

1.0 Introduction

1.1 This is the report of a Domestic Homicide Review (DHR) undertaken by North Somerset Safer Communities Partnership and examines the interaction that local agencies had with Piotr, prior to his death in 2021.

1.2 The key purpose for undertaking a DHR is to enable learning from those deaths where a person has died and where domestic abuse, was or could have been, a factor. In order for the learning to be shared 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 tragedies happening in the future.

1.3 North Somerset Safer Communities wanted to review the death of Piotr in order to establish if there had been effective intervention by agencies and whether he had been a victim of abuse prior to the incident taking place.

1.4 Piotr died at his home address in North Somerset in early 2021. On that date Filip had contacted the Ambulance Service and stated that someone had broken in to his home address and they had killed his father whilst he was hiding under his bed. On arrival officers forced entry to the rear of the house and found Piotr in an upstairs bedroom with stab wounds to his body. Paramedics arrived and attempted CPR before eventually pronouncing Piotr as deceased. Later that same day Filip was arrested for the murder of his father and was conveyed to custody.

1.5 This report will consider the contact and involvement that agencies had with Piotr between September 2017 and April 2021. The reason that members of the Panel chose these dates is that they provide a time frame during which agencies had contact with Piotr and his family, including Filip. Members of the Panel wanted to understand and learn from Filip's experiences of service contact and the support that was provided to him. The Panel were also interested in whether risks were identified at the earliest possible opportunity and action taken to mitigate them.

1.6 Members of the Panel and Individual Management Review (IMR) writers have used the DHR process to examine whether there were opportunities to provide Piotr and his family with additional support. This was done by looking holistically and critically at agency involvement with the family with a view to identifying whether additional action could have protected Piotr from harm and mitigated the risks of domestic abuse. Piotr's family were also integral in identifying the lessons relating to partnership working and their involvement is detailed in section 5.0.

1.7 Every effort has been made to conduct this review process with an open mindset and to avoid hindsight bias. Those leading the review have made every attempt to manage the process with compassion and sensitivity.

2.0 Timescales

2.1 The decision to commission a review was taken by the Chair of the North Somerset Safer Communities Partnership on the 5th May 2021. The Home Office had been informed of the decision to undertake a review on the 20th May 2021. The review was conducted in line with the Home Office Multi Agency Statutory Guidance for the conduct of Domestic Homicide Reviews (2016).

2.2 The Home Office Statutory Guidance advises that where practically possible the Domestic Homicide Review should be completed within six months of the decision made to proceed with the process. For this reason an initial timetable was drawn up to ensure that agencies complied with this request.

2.3 The review was unable to be completed in the six-month time frame due to the complexity of the judicial process and the request from Piotr's wife that she wanted to be included in the process but needed time to grieve before doing so. The trial was concluded in the November 2021 and Piotr's wife was interviewed in late June 2022. The Panel had also made the decision that the review should be delayed so that the information from the Mental Health Homicide Review could also be considered. A further comment on this is detailed in section 9.2.

2.4 The Independent Chair was appointed on 28th May 2021 and the review was commenced. The first panel meeting was held on the 15th June 2021. During this meeting, the draft terms of reference were discussed and the members of the Panel agreed upon their content.

2.5 The review concluded in July 2022. The North Somerset Safer Communities Partnership actively reviewed the progress of the review throughout the process.

3.0 Confidentiality

3.1 The findings of this review are confidential. The Information obtained as part of the review process has only been made available to participating professionals, and their line managers.

3.2 Before the report is published the North Somerset Safer Communities Partnership will circulate the final version to all members of the review panel, the Chief Executives of their agencies, and Piotr's wife. The family will be notified of the publication date.

3.3 The content of the overview report has been anonymised to protect the identity of the relevant family members and all others involved in this review. Piotr's wife chose the pseudonyms for her husband and son. Family composition and pseudonyms used.

- Piotr – Deceased male
- Filip – Son
- Piotr's wife
- Filip's girlfriend.

3.4 Filip and his family had attended two UHBW hospital sites within the dates set by the terms of reference. For the purposes of this review these have been referred to as Hospital 1 and Hospital 2.

4.0 Methodology

4.1 Domestic Homicide Reviews were established on a statutory basis under section 9 of the Domestic Abuse, Crime and Victims Act (2004). The Act, which came into force on the 13th April 2011, 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 he/she was related or with whom he/she was or had been in an intimate personal relationship or;

b. A member of the same household as him/herself; held with a view to identifying the lessons to be learnt from the death'.

4.2 The review was commissioned with a view to identifying whether the relationship between Filip and his father had been abusive and whether this had indirectly contributed to his death.

The purpose of the review was therefore set to;

- Establish the facts that led to the death of Piotr and whether there was learning in the way in which local professionals and organisations carried out their responsibilities and duties and worked together to safeguard Piotr;

- Identify clearly the learning, how this will be acted upon, and what is expected to change as a result;

- Apply the learning to service responses including changes to policies, procedures and practice of individual agencies, and inter-agency working, with the aim to better safeguard victims of domestic abuse in North Somerset;

- Identify what needs to change in order to reduce the risk of such tragedies happening in the future and improve single agency and inter-agency responses to all domestic abuse victims and their children through improved partnership working;

- Identify, on the basis of the evidence available to the review, whether the death of Piotr was avoidable, with the purpose of creating a joint strategic action plan to address the gaps and improve policy and procedures in North Somerset;

- Identify from both the circumstances of this case, and the review process adopted in relation to it, any learning which should inform policies and procedures in respect to national reviews and make this available to the Home Office.

4.3 In addition to the above, the following terms of reference were set by the DHR panel and there was a requirement that these were addressed in the overview report;

1. To provide an overview report that articulates the Piotr's life through his eyes, and those around him, including professionals.

2. Establish the sequence of agency contact with Piotr/Filip, and the members of their household (between the dates of September 2017 and April 2021); and constructively review the actions of those agencies or individuals involved.

3. Provide an assessment of whether the death of Piotr was an isolated incident or whether there were any warning signs that would indicate that there was any previous history of abusive behaviour towards the deceased and whether this was known to any agencies.

4. Seek to establish whether Piotr or Filip was exposed to domestic abuse prior to adulthood and impact that this may have had on the individuals concerned.

5. Establish whether family or friends want to participate in the review and meet the Review Panel.

6. Provide an assessment of whether family, friends, neighbours, key workers (if appropriate) were aware of any abusive or concerning behaviour in relation to the victim (or other persons).

7. Review any barriers experienced by the victim/family/friends in reporting any abuse or concerns in North Somerset or elsewhere, including whether they knew how to report domestic abuse.

8. Assess whether there were opportunities for professionals to enquire or raise concerns about domestic abuse in the relationship.

9. To review current roles, responsibilities, policies and practices in relation to victims, perpetrators and families of domestic abuse and identify best practice.

10. To review national best practice in respect of protecting victims and their families from domestic abuse.

11. An evaluation of any training or awareness raising requirements that are necessary to ensure a greater knowledge and understanding of domestic abuse processes and/or services in North Somerset.

12. Whether the work undertaken by the services in this case was consistent with their own professional standards and compliant with their own protocols, guidelines, policies and procedures.

13. Establish whether thresholds for intervention were applied appropriately in this case.

14. Consideration of any equality and diversity issues that appear pertinent to Piotr and/or family members e.g. age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex and sexual orientation.

15. To clearly identify learning and draw out conclusions about how organisations and partnerships can improve their working in the future to support victims of domestic abuse.

16. To clearly articulate how learning will be acted upon, and what is expected to change as a result.

17. To identify whether there is a need for changes in organisational and/or partnership policy, procedures or practice in North Somerset in order to improve our work to better safeguard victims of domestic abuse and their families.

18. To identify good practice.

19. To review any other information that is found to be relevant.

The Review excludes consideration of how Piotr died.

4.4 The methods for conducting DHR's are prescribed by the Home Office guidelines[1]. These guidelines state;

'Reviews should illuminate the past to make the future safer and it follows therefore that reviews should be professionally curious, find the trail of abuse and identify which agencies had contact with the victim, perpetrator or family and which agencies were in contact with each other. From this position, appropriate solutions can be recommended to help recognise abuse and either signpost victims to suitable support or design safe interventions'.

4.5 In order to ensure that the review was comprehensive, the North Somerset Safer Communities Partnership contacted twenty two agencies to see if they had contact with the family. The Partnership then arranged for nine agencies who were identified as having contact with Piotr and his family to check their records for all relevant information.

4.6 All of those agencies who were identified as having contact with the family were asked to secure relevant documents, and appropriate members were invited to become panel

[1] Multi Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews; Home Office: Dec 2016

members. Individual Management Reviews were requested from those agencies who had contact with the family (these are specified at section 6.0).

4.7 Additional information was also reviewed by the Chair of the Panel and this included reading national DHR's involving Polish nationals, and reviewing policies and procedures. The Chair also attended a conference and workshops Organised by Vesta[2] which specifically related to domestic abuse and its effects on the Polish community. This event provided additional context and information relevant to this review.

4.8 All of the relevant agencies identified independent and experienced staff members to complete chronologies. These members of staff didn't know the individuals involved, or had direct involvement in the case. None of them had direct line management responsibility for any of the professionals who had been involved with the family.

5.0 Involvement of family, friends, neighbours and the wider community

5.1 Piotr's wife and son's girlfriend were invited to contribute to the review. These individuals were provided with a leaflet prepared by the Home Office about the DHR process. The process was also explained to them by the Police Family Liaison Officer and their Victim Support Worker. The family were also provided with the Advocacy After Fatal Domestic Abuse Leaflet and the terms of reference. Family members were also signposted to support services.

5.2 Whilst Piotr's family members were approached and encouraged to take part in the DHR process only Piotr's wife chose to be interviewed by the report author. The Panel appreciated that Filip's girlfriend may not want to participate in the review for a variety of personal reasons.

5.3 The Panel had explored whether there were any opportunities to speak to other family members, neighbours and friends. Contact with the family and the police investigation had shown that the they had no other family members in the UK and no known friends. Consideration was also given to contacting other family members in Poland but the Police investigation had not identified an appropriate person to talk to during the review period. The police investigation identified that Piotr's wider family network were unaware of the issues being faced by the family in terms of Filip's mental illness and the abuse that was occurring in the household. This was later confirmed by Piotr's wife.

5.4 The police investigation had also identified that the family were very private and they had not interacted with their neighbours. The neighbours that were spoken to by officers were unaware of the abuse that was occurring in the household.

[2] Vesta Specialist Family Support CIC support Polish families with domestic violence issues through therapeutic courses for victims, counselling and short one-to-one interventions with individuals engaging in abusive behaviour. They also focus on improving parenting skills and general well-being of the Polish families.

5.5 Filip was invited to participate in the review. A letter was sent to his solicitors to establish if he wanted to meet with the Independent Chair and/or a member of North Somerset Partnership. Filip declined this invitation to be part of the review process.

5.6 The work colleagues of Piotr only knew him on what they describe as a 'casual' basis and were unable to offer any additional information to assist the review. Piotr had not mentioned that he or his family were victims of abuse within the work environment.

6.0 Contributors to the Review

6.1 The contributors to the DHR were;

- Avon and North Somerset Constabulary (ASC) – IMR, access to investigative records/Domestic Abuse Stalking and Harassment and Honour Based Violence (DASH) risk assessments.
- Adult Social Care – Information/advice.
- Children's Services - Information/advice.
- North Somerset housing – Information/advice.
- Child and Adolescent Mental Health Services – IMR.
- South West Ambulance Services – Records, Information.
- Filip's College – IMR
- University Hospitals Bristol and Western NHSF Trust (UHBW) - IMR.
- Piotr and Filip's General Practitioner (GP) - IMR.
- Avon and Wiltshire Mental Health Partnership NHS Trust (AWP) – IMR.
- Next Link – information.
- Vesta- Specialist domestic abuse advice and information.

6.2 Specialist domestic abuse advice and scrutiny was provided by a Senior Service Manager from Next Link. Next Link are the commissioned service for domestic abuse services across all of North Somerset, Bristol and South Gloucestershire. Referrals are received by Next Link as self-referrals or from agencies if cases are considered to be 'High Risk'. In this review the organisation confirmed that none of their staff ever supported the parties involved.

6.3 In terms of the wider issues faced by the Polish community additional advice was sought from the Inclusion and Corporate Development Manager for North Somerset.

6.4 Specialist support in terms of advice relating to domestic abuse and the Polish Community was provided to the Panel by a member of Vesta Specialist Family Support CIC.

6.5 The review identified that drugs and alcohol misuse was a contributory cause to the decline in Filip's behaviour. Contact was made with the Drugs and Alcohol Service (We are With you) in North Somerset and they confirmed that no referrals were made to their service. This will be discussed further in Section 15.0.

6.6 All of the IMR writers were independent. None of the writers members knew the individuals concerned, had direct involvement in the case, or had line management responsibility for any of those who had come into contact with the family.

7.0 The Review Panel Members

7.1 The Panel for this review were made up of the following representatives;

- Paul Northcott-Independent Chair
- Hannah Gray – Domestic Abuse & VAWG Lead, North Somerset Council (NSC)
- Howard Pothecary – Safer Communities Service Manager NSC
- Kate Hebden – Homicide case Worker, Victim Support
- Claire Price – Leadership and Learning Consultant/ Designated Safeguarding Lead - Oasis Academy Brightstowe, Education
- Alan Dale – Principal - Oasis Academy Brightstowe, Education
- Michelle Jennings – Team Leader, Children's Social Care
- Jo Baker – Service Leader for Strategic Safeguarding and Quality Assurance
- Richard Worrin – Detective Constable- Major Crime Team (ASC)
- Lucy Edgeworth – Detective Constable- Major Crime Team ASC
- Paulette Nuttall – Head of Adult Safeguarding, BNSSG CCG
- Jacqueline Keane – Former Operational Lead Nurse for Safeguarding Adults (UHBW)
- Danielle Rowan – Domestic Abuse Lead, AWP
- Clare Shaw – Safeguarding Associate Practitioner, Safeguarding Team, AWP
- Kelly Smith – GP Lead Nurse, Pier Health Group
- Nancy Southcott – Locum acting Clinical Service Manager for CAMHS /AWP North Somerset
- Ewa Wilcock - Vesta -Specialist Family Support CIC
- Jayne Whittlestone – Senior Service Manager – Next Link

7.2 The North Somerset Safer Communities Partnership ensured that there was scrutiny and accountability throughout the DHR process particularly in respect of independence and impartiality. The impartiality of the independent Chair and Panel members are essential in delivering a process and report that is legitimate and credible. None of the panel members knew the individuals involved, had direct involvement in the case, or had line management responsibility for any of those involved. This was confirmed by agencies at the initial panel meeting.

7.3 Responsibilities directly relating to the commissioning body, namely any changes to the terms of reference and the agreement and implementation of an action plan to take forward the recommendations in this report, are held by the North Somerset Safer Communities Partnership.

7.4 The Panel met formally on five occasions. Contact was made with panel members on a regular basis outside of the formal meetings to clarify issues and matters of accuracy about their agency's involvement with the family. Documents including draft

reports were circulated electronically to members and discussed on an individual basis as were the themes identified from the review process.

7.5 All of the Panel members were independent. None of the members knew the individuals concerned or had direct involvement in the case.

8.0 Author of the Overview Report.

8.1 The North Somerset Safer Communities Partnership appointed Paul Northcott as Independent Chair and author of the overview report on 28th May 2021.

8.2 Paul is a safeguarding consultant specialising in undertaking reviews and currently delivers training in all aspects of safeguarding, including domestic abuse. Paul was a serving police officer and had thirty-one years' experience. During that time he was the Head of Public Protection, working with partner agencies, including those working to deliver policy and practice in relation to domestic abuse. He has also previously been the senior investigating officer for domestic homicides.

8.3 Paul has not directly worked in the North Somerset area and retired from the police service in February 2017. Paul has not worked for North Somerset Safer Communities Partnership, nor any of the agencies involved in this review.

8.4 Paul has been trained as a DHR Chair, is a member of the DHR network and has attended AAFDA[3] webinars.

9.0 Parallel Reviews

9.1 Following the police investigation the death of Piotr was referred to the HM Coroner's office. HM Coroner made the decision that there was no requirement for an inquest in view of the outcome from the court process.

9.2 A decision was made by NHS England not to undertake a Mental Health Homicide Review in this case. The Panel had initially been waiting for this decision to identify if further learning could be identified to inform the DHR process. A decision was made by North Somerset Partnership that to prevent a further delay in submitting the DHR, and to meet the family's needs, the final report should be submitted as a standalone document.

10.0 Equality and Diversity.

10.1 The review adheres to the Equality Act 2010 and all nine protected characteristics (age, disability, gender re-assignment, marriage and civil partnerships, pregnancy and maternity, race, religion and belief, sex or sexual orientation) were considered by the Panel as part of the terms of reference and throughout the review process.

[3] Advocacy after fatal domestic Abuse.

10.2 It is acknowledged that Domestic Homicides (DH) are overwhelmingly known to affect women[4] in that they are significantly more at risk of being killed by a partner or family member than men[5]. Research in terms of male victimisation and empirical analysis of homicides in which children have killed their parents has been limited[6].

10.3 Piotr was a white Polish national and heterosexual. Piotr was aged thirty eight at the time of his death. Filip was also a Polish national and Heterosexual. Filip was aged eighteen at the time that Piotr died.

10.4 As far as the Panel has been able to determine, Piotr and his family did not hold any strong religious beliefs.

10.5 In terms of diverse backgrounds, research in Poland has determined that key factors shaping individual experiences can increase the risk of experiencing domestic violence and abuse and these can include;

- Their history of migration and settlement in the UK
- Prior understanding of domestic abuse, derived from their home county
- Lack of knowledge of services in the UK and fear about the services
- Language barriers and socio-cultural/religious and political context when understanding their situation

Whilst this research[7] relates to women many of its principles could be applicable in this case.

10.7 There is no evidence that would indicate that Piotr or Filip were directly discriminated against by services or individuals with whom they came into contact with although the lack of understanding of cultural differences and perceived language barriers did have an impact on effective service delivery. Both Piotr and Filip had a good command of the English language but Piotr's wife and Filip's girlfriend required additional help through interpreters.

10.8 Filip's recent migration history did have a direct impact on his behaviour in terms of his feelings of isolation due to him missing his friends and his girlfriend.

10.9 Piotr's wife has stated that whilst she and her husband lacked knowledge in terms of the services that were available to assist them, they would not have hesitated to contact them if they needed their help.

10.8 From the documents reviewed and from the interview with Piotr's wife it was clear that on many occasions staff within agencies had failed to recognise the barriers that existed in communication and provide the family's with sufficient time to understand

[4] Ruuskanen and Kauko, 2008.
[5] In the year ending March 2016, there were fifty-seven male and 113 DH victims in England and Wales, representing 14 per cent of all male and 65 per cent of all female homicide victims (ONS, 2018b)
[6] Holt (2017)
[7] Zielinska et al(2022)

the way that services worked. Areas such as the cultural understanding of mental health and domestic abuse were never fully explored with the family which in turn impacted on the decisions that they made including their sense of risk, safety at home and their acceptance of the services that were offered to them. Barriers to accessing services will however be discussed in section 15.

10.9 Age was a factor in this case as Piotr was killed by his son. Research [8] has identified that the true extent of Child to Parent Violence and Abuse (CPVA) is difficult to determine, although it is suggested that this is a wider and more complex issue than previously reported. Reported CPVA often shows that for some young people levels of stress and mental anxiety can increase the risks of this type of abuse occurring.

10.10 In relation to Filip his age as a child does not appear to have been fully considered in the initial stages of contact with agencies. This did not however appear to have been a barrier to accessing the services that he required in terms of his mental health.

11.0 Dissemination

11.1 Following approval from by the Home Office the final report will be disseminated to the following organisations/partnerships;

- North Somerset Council
- Victim Support
- Education
- Horizon Health Care
- Avon and North Somerset Constabulary
- University Hospitals Bristol and Weston NHSF Trust
- Avon and Wiltshire Mental Health Partnership NHS Trust
- BNSSG CCG
- Piotr's GP
- CAMHS
- Vesta -Specialist Family Support CIC- Nominated representative only
- Next Link
- We Are With you (WAWY)

11.2 In accordance with Home Office guidance all agencies and the family of Piotr are aware that the final overview report will be published. Although key issues have been shared with specific organisations, the overview report will not be disseminated until clearance has been received from the Home Office Quality Assurance Group.

11.3 Once agreement has been reached the report will be disseminated to all organisations detailed in paragraph 11.1. Piotr's wife was provided with a copy of the draft report for comment prior to it being finalised. This report was translated into Polish. A translated final report will also be sent to Piotr's wife.

[8] Bonnick, H (2019)

12.0 Background Information (The Facts)

12.1 Piotr's wife came to England Sept 2015 and was joined by her husband in the November of that year. Filip joined his parents in June 2016. At the time Filip had been in a long term relationship with another female (described "as the love of his life") and his mother described that by coming to England he had felt isolated and resentful that the relationship had to continue 'long distance'. He used to say to his parents "Why did you do this to me?"

12.2 Piotr was described by his wife as, helpful, friendly man who was able to care for his family. He was seen as the ''head of the family' and took responsibility for managing their affairs in the UK. Piotr's wife described her son as having all of the qualities of his father in terms of his personality and family commitment.

12.3 All three family members lived in a house in North Somerset which they owned. They were private people with no known friends and limited contact with their neighbours.

12.4 Piotr's wife stated that she and her husband noticed a significant change in Filip's behaviour in the September of 2020. They had joined their son whilst he was on holiday in Poland. She stated that he would ask them to give him things such as growth hormone and when they didn't agree to his demands, he would become aggressive. They had not witnessed such behaviour previously.

12.5 Filip's girlfriend came to England in Oct 2020. She had known Filip for about five years as the two of them had met at school. The two of them had become a couple in the summer of 2020 after his previous relationship had ended. When Filip's girlfriend first arrived in England she stayed at the family's home address.

12.6 From April 2020 onwards Filip's mental health had deteriorated. His mother stated that COVID restrictions had made Filip feel increasingly isolated. He had started smoking cannabis and drinking alcohol to excess and this had led to him becoming paranoid and unable to sleep. The deterioration in his mental health also led to him fabricating stories about his parents (Police report 24/10/20). In this case referrals should have been made to drugs and alcohol support services, and Children's Social Care but weren't and this will be discussed further in section 15.0.

12.7 Filip had become verbally and physically aggressive to both of his parents and his girlfriend. This escalation in his behaviour was out of character and was concerning to those who knew him. On one occasion Filip had threatened his father and girlfriend with a knife and he had held his girlfriend by the throat as detailed in the chronology and at section 15.0.

12.8 Filip would present to Health professionals at times of crisis. This contact was always instigated by his family who would seek out support in an attempt to help their son.

12.9 Filip was admitted to hospital and detained under the Mental Health Act 1983. On being discharged Filip was being treated by the Mental Health Team in the community. At

that time his girlfriend had moved out of the home address, but she would return on occasions to stay with the family.

12.10 In the seven to ten days prior to the death of Piotr his parents would lock their son in the house when they were not there. His parents believed that his mental health was deteriorating and that given the opportunity he would leave the house to buy more alcohol or marijuana. Both parents felt very protective of their son and believed that by locking him in they were actively trying to manage his behaviour and minimise the risk of harm to himself and others.

12.11 On the day prior to his father's death Filip had received his monthly medication which was administered by injection at the home address. Later that day Filip had also taken his prescribed diazepam and drank two beers. Filip then stated that he was going to bed as he felt unwell. Filip then slept most of the day.

12.12 Piotr's wife and Filip's girlfriend left the home that evening to go to work. Piotr's wife locked Filip in the house and hid the keys. Later that night Filip rang his mother to ask where the keys were but she did not tell him. She told him to call Piotr if he needed anything. This was the last time Piotr's wife spoke to her son. During the night Piotr had sent a number of text messages to his wife. These did not suggest that there were any issues with Filip.

12.13 That night Filip made a 999 call for an ambulance informing them that someone had broken into his home and killed his dad. He stated that he had been hiding under his bed when this had happened. When the first officers arrived at the house, they could see Filip through the front door but he told them that he could not unlock it. The officers in attendance described Filip as being tearful but compliant. Officers forced entry into the premise so that paramedics could enter the property. Piotr was found in an upstairs bedroom which was described by one officer as being "untidy" and the TV was still on. Piotr was lying on the floor in just his underwear with multiple stab wounds to his body. Filip was arrested for attempted murder and taken into custody. Piotr did not regain consciousness during the time that officers and paramedics were at the scene and Filip was later arrested for murder and informed of his father's death.

12.14 Filip was subsequently interviewed but did not comment about the incident. Due to his mental state Filip was later transferred to a secure psychiatric unit where he remained until his trial.

12.15 A forensic postmortem of Piotr's body was carried out which concluded that he had died from stab wounds to his chest.

12.16 Filip appeared before a criminal court and after hearing the evidence during the trial a decision was made by the prosecution to withdraw the murder indictment and to allow the jury to determine a charge of manslaughter. This decision was reached as it was evident during the trial that Filip was clearly mentally unwell and that this level of mental illness diminished his responsibility. Filip was found guilty of manslaughter in

December 2021. He was sentenced and detained under a Hospital and Restriction Order[9]. Filip has been diagnosed with paranoid schizophrenia.

12.17 During the court hearing no additional information was identified that would have assisted the review other than that which had been presented through the Police investigation.

13.0 Chronology

13.1 Piotr and his wife were a tight family unit who cared for their son. All of the family were private people and there was little information provided to the review about their history in Poland. From the discussion with Piotr's wife it would appear that they were a 'normal' family striving to improve their circumstances through moving to the United Kingdom. The family were hard working and respectful.

13.2 The chronology date set for this review was from of September 2017 and April 2021 as these dates provide a sufficient time span that capture the deterioration in Filip's behaviour. Only issues of relevance have been included in the chronology below hence it commencing in June 2020. The incidents prior to those detailed in the below chronology related to Filip's drugs misuse so have not been included in detail but will be considered further in section 15.

Date	**Incident**
26/06/20	Filip made an abandoned 999 call. Police officers were dispatched and on arrival those present at the address were found to be calm and no immediate concerns were identified. Filip stated that he had had an argument with his father. When asked why he had called the police he said that he did not know and did not want to provide any additional information. Piotr explained to the Police that he had told Filip that he would call them if his (Filip's) behaviour did not improve. As a result Filip had decided to "get in first" and call the police himself. Officers completed a DASH[10] assessment. Appropriate referrals were made to Children's Services and Children's Health Services.
24/10/20 17.49hrs 19.37hrs	Filip attended the Emergency Department of his local hospital (Hospital 1) accompanied by his father. Piotr was concerned for the Filip's' mental health. He reported that Filip was presenting as paranoid and agitated and had locked his girlfriend in the bathroom stating that she was planning to kill him and he believed that his father had impregnated her (she was not pregnant). Filip discharged himself after being triaged before further assessment. Filip walked out of triage laughing to himself and singing, and displaying symptoms of paranoia. Filip made comments that he thought he had AIDS. Staff at the

[9] Mental Health Act 1983

[10] DASH – Domestic Abuse, Stalking and Harassment and Honour-based abuse Toolkit. A nationally implemented took used to assess victim risk in cases of domestic abuse. It enables officers to assess the risk of serious harm to the victim to support safeguarding decisions. Ideally the completion of the DASH assessment will be victim-led but it can be completed by the officer alone based on their perception of the level of risk based on what is known about the victim and the perpetrator.

	hospital requested that an ambulance should attend his home address to check on his welfare.
24/10/20 21.29hrs	Filip was returned to the hospital Emergency Department (Hospital 1) by paramedics. There was some miscommunication between ambulance control and mental health team as the AWP street triage team had said the ambulance should have left Filip at home if he was stable. They stated that he could have attended another hospital the next day, for a planned assessment with the child and adolescent team. Filip was assessed as "stable" so he was discharged home overnight and a follow up appointment was arranged for a CAMHS review.
24/10/20 23.59hrs	Filip was taken to the Emergency Department (Hospital 2) via ambulance with symptoms felt to be psychosis related. Piotr had called an ambulance as Filip had a knife and was being increasingly aggressive to his mother and his girlfriend. He also stated that he had "put his girlfriend in the shed' and also mentioned that Filip had taken hold of a knife and was "grabbing [his] girlfriend by neck, threatening and aggressive". Filip was alleging that his father had hurt him. The police had asked paramedics to attend the incident due to issues of psychosis and mental capacity. Piotr's wife attended the hospital at 4am and spoke with her husband. There was no interpreter present and Piotr had to explain to hospital staff about what had happened. Filip attempted to run away on a number of occasions. Filip was kept in the department overnight. The plan was to return him in the morning to Hospital 1 for a mental health review.
25/10/20 08.00hrs	Filip ran away from hospital 2.
25/10/20 08.55hrs	The Police received a call from hospital 2 reporting that Filip had gone missing whilst awaiting mental health assessment. At this point Filip was still 17 years old. The caller explained that Filip had been taken to the hospital following an incident at the family home where he had threatened Piotr with a knife (although Piotr's wife had not witnessed this). They also explained that Piotr's wife seemed scared of Filip. Police officers searched the area and were later contacted by his parents who stated that he had contacted them and would be returning home later that day. Officers later completed a welfare check and spoke to Piotr. The officers were told that Filip was asleep. Piotr did not make any further complaint about the incident that had led to Filip being taken to the hospital. On this occasion officers completed the DASH[11] assessment process with Piotr and there were no disclosures by either Piotr or his wife that they feared any violence from Filip. Officers completed a BRAG assessment for Filip. This document noted that Filip appeared to have had a psychotic episode potentially caused by

[11] DASH – Domestic Abuse, Stalking and Harassment and Honour-based abuse Toolkit. A nationally implemented took used to assess victim risk in cases of domestic abuse. It enables officers to assess the risk of serious harm to the victim to support safeguarding decisions. Ideally the completion of the DASH assessment will be victim-led but it can be completed by the officer alone based on their perception of the level of risk based on what is known about the victim and the perpetrator.

	excessive cannabis use and that the impact of his behaviour on his family was 'hard'. Piotr and his wife told officers that they were going to contact their GP the next day and arrange an appointment for Filip. To support them officers tasked to the Lighthouse Safeguarding Unit (LSU) for additional support.
27/10/20	The Early Intervention Team (EI) received a referral from CAMHS for Filip. The referral stated that he had reported that his girlfriend had moved into the family home. It referred to Filip being very distressed and that he had reported to the police that his parents were trying to hurt him. Filip had old self-harm scars. Filip reported that he had tried to assault his mother. The referral stated that the Police do not believe that he poses 'a risk to others".
27/10/20	The Police received a 999 call from Filip during which he had stated that his mother had assaulted him. A separate call was then received from Piotr who stated that he and his wife had been trying to take Filip to hospital because of his paranoia and that he [Filip] has been trying to harm people. Piotr stated that Filip tried to hurt his girlfriend. Piotr stated that the only reason for Filip to have called the police was because he was trying to avoid being taken to hospital. Filip had become verbally aggressive. The police attended and verified the accounts given. Piotr's wife had stated that the assault (a slap to his face) on her son was a pre-exemptive strike due to his aggressive behaviour. Filip's girlfriend stated that he was very aggressive and always angry. She told officers that two days ago Filip had grabbed her by the neck. No complaints were forthcoming and the officers completed a DASH with and Piotr and his wife (a DASH was not completed for his girlfriend). The officers assessed their risk as high. No separate DASH was completed with Filip.
03/11/20	Piotr made a 999 call to the Police during which he stated that Filip had assaulted his girlfriend during an argument. Officers attended the address and Filip stated that the argument had taken place due to him becoming aware of his girlfriend's relationship with his father. Filip's girlfriend reported to officers that during the argument he had grabbed her by the neck and pushed her. Filip was subsequently arrested for the assault and whilst in custody a mental health assessment was undertaken. Prior to his arrest Filip had said to Piotr "I'LL KILL YOU FOR TOUCHING [Filip's girlfriend]". Both Filip's girlfriend and Piotr declined to make a complaint and it was determined that there was insufficient evidence to progress a victimless prosecution. Filip was detained under section 2 of the Mental Health Act 1983. Further assessments were later carried out and Filip was detained in a secure unit. Filip was described as highly agitated and paranoid.
11/11/20	EI contacted the secure unit and spoke to Filip as he was appealing against his detention. Records state that EI believed at that time that his mental health appeared to have improved although they state that Filip 'offers little insight into this'. When EI spoke to Filip's father, he agreed that his son was making

	progress. His father stated that the decline in his sons mental health was down to recent excessive use of substances. Filip was diagnosed with non-organic psychosis at this time (*although his mother has stated that his neither she nor her husband were informed of this*).
16/11/20	A Healthcare Assistant had a conversation in Polish with Filip regarding the circumstances of his admission. Filip appeared calm and responsive to the conversation at that time although he was reported to have little insight into his behaviour with others. During the ward round Filip denied that he had any mental health issues. He stated that he didn't remember assaulting his girlfriend and felt that things were going well at home. Filip admitted that he "may" have believed that his father had developed a relationship with his girlfriend due to' the voices he had heard'.
23/11/20	The secure unit had a discussion about a MARAC referral. The Units record show that the Police were unsure if a previous MARAC referral had been completed. The outcome was that the nursing team were to complete a DASH and MARAC referral. The team were also going to notify Filip's girlfriend of the referral and liaise further with the Police.
25/11/20	The secure unit called Filip's girlfriend to compete a DASH. The DASH assessment considered his girlfriend to be 'high risk'. The records showed that the DASH and MARAC referrals were made.
27/11/20	A Mental Health Act Assessment was completed at the secure unit. This assessment stated that Filip 'remains at high risk to himself and others if not detained' and that 'recent behaviour is still worrying. But the trajectory is improving'. The report further states that Filip does not understand why he is hospital and although 'compliant with assessment [he] may be disguising behaviours at times'.
07/12/20	The secure unit spoke to Filip's father. He stated that his son had started using cannabis infrequently and he had then noticed an increase to almost every day back in March/April when Filip had become fixated on obtaining bulking hormone[12]. Filip had become aggressive and Piotr was concerned about the safety of his [Filip's] girlfriend. He stated that Filip was jealous and felt that his girlfriend was having an affair with him. Arrangements were made for Filip's girlfriend to move out.
08/12/20	The secure unit spoke to Piotr to discuss discharge plans and the incidents around Filip's girlfriend. Filip was believed to have split up from his girlfriend. Piotr stated that Filip and girlfriend will often 'argue but there was no aggression'. Filip at that time believed that they are still having an affair.
14/12/20	Filip was discharged from the inpatient ward. His discharge plan documents that there had been 'significant recovery' and that there were 'no safeguarding issues'.
15/12/20	North Somerset Intensive Team contacted Filip following his discharge. He appeared calm and pleased to be discharged. Filip's girlfriend was no longer living at the address. Filip wanted support in dealing with longer term issues with family.

[12] Natural hormones used in bodybuilding and strength training.

18/12/20	EI completed a home visit. Filip was keen to stress that he had no intention of returning to cannabis use and agreed with his treatment plan. Filip wanted help in finding employment. Filip appeared to be settled with family life and there was no apparent deterioration in his mental health at that time. The records stated that a MARAC and DASH had been completed but that it was unclear whether a formal referral had been made.
30/12/20	EI team conducted a medication review. Filip attended with his mother. At that time he was still demonstrating a lack of insight into previous events but appeared to be mentally stable and wanted to find a job. The records state that there was 'no current substance misuse and he realises that this may have contributed to his poor mental health'. The plan was to discharge Filip from the Intensive Team back to the Early Intervention Team.
15/01/21	EI conducted a home visit. Filip appeared well with no obvious sign of mental health deterioration. Filip was still abstaining from illicit substances and his father was apparently regularly screening his urine (although there was no evidence found in records or by the Police investigation to confirm that this was actually taking place). Filip was still in denial about the significance of his hospital admission. The family were described as being ambivalent around undertaking family psychological intervention work at that time.
12/02/21	EI conducted a home visit. Piotr stated that there were some worrying signs as Filip had gone out in the early hours to meet friends (although the Police investigation never identified any friends) and had a smoke (although Filip stated it was tobacco). Filip was refusing to urinary screen at that time. Piotr wanted Filip to find employment otherwise he feared that he would 'get back into bad habits'.
14/02/21	EI contacted Piotr. Filip had lost his job. They offered support. Piotr stated that Filip had been drinking because he had been bored.
24/02/21	An IPS worker met with Filip. At that time he was keen to find full time employment. He stated that he wanted to make more friends and be more sociable.
19/02/21	EI met with Filip and an IPS worker. At that time his mental health appeared stable. He was described as 'future orientated'.
12/03/21	EI were contacted by Piotr to state that Filip was unable to make an arranged appointment. He had apparently had an altercation at work and needed to see a manager. Piotr reported that Filip was using cannabis again.
15/03/21	Filip was seen by EI staff. He admitted to using small amounts of cannabis as he didn't have much money and also one or two beers to help him relax. He stated that he would be drinking alcohol at the weekend when he saw his girlfriend (although they still remained separated at that time).
25/03/21	Piotr contacted the EI team with a request to see if an interpreter could be used as his wife wanted to talk about Filip.

07/04/21	EI received a telephone call from Piotr. He stated that there had been a change in Filip's presentation. Filip had lost his job again.
09/04/21	An assessment was carried out with Filip and a Care Coordinator from EI. Initially Filip did not want parents to be present but this was reviewed part way through and then agreed to their attendance. Those present stated that there were tensions at times with Filip and his parents. Filip denied any mental health problems but was happy to continue on medication. He also denied using cannabis since losing his job. Filip admitted to drinking cider mixed with beverages recently. His parents felt that his alcohol consumption was more excessive than he was admitting and that he was using cannabis. The records state that in their opinion that recent events are due to losing his job together with using cannabis. On that occasion the doctor stated that there was no sign of psychosis and no sign of low mood or depression. Admission to hospital was considered but it was felt that this was not necessary as Filip was compliant with his medication routine. Filip was questioned about his girlfriend and his father and he replied that he thought it was 'ridiculous to think that way' (this would appear to relate to his perception about their relationship). Filip was described as future focused and was not displaying any abnormal behaviour. At that time it was assessed that Filip had 'no thoughts of self-harm or to harm others'. A referral was made to the Intensive Team due to the increase in stress levels and concerns raised by the family. Opportunities to support Filip to find suitable employment were also discussed.
10/4/21	A home visit was carried out by the Intensive Support Team (IST). Filip was upstairs at the start of visit and reluctant to come down. He was argumentative with his parents. Piotr stated that he was concerned about the current mental health of Filip. Piotr stated that Filip had 'a physical concern' but he would not elaborate. Filip was described as being very anxious that he would be re-admitted to hospital. Filip did eventually come down and announce that he was well and did not need help. Filip then asked his father to take him to hospital. Those carrying out the visit stated that Filip went to great efforts to try and convince IST that he was fine.
12/4/21	EI Carried out a home visit. Filip was not present at that time. Piotr had stated that an increase in medication had made Filip more settled but there were still concerns that his mental health was 'not the best'. Filip on return was found to be detached during visit and 'remained suspicious and guarded'. Filip was encouraged to engage with the Intensive Team and those present tried to re-assure that no one wanted him to go to hospital.
April 2021	Date of death.

14.0 Overview

14.1 This overview will summarise what information that was known to the agencies and professionals who were involved with Piotr and his family. It will also include any other relevant facts or information about Piotr and Filip.

14.2 Piotr was a family orientated and private individual who had no known friends or close work colleagues. Piotr worked shifts as a delivery driver for a National company based in the locality.

14.3 There was a family history of psychosis with Filip's grandfather diagnosed with schizophrenia. According to his wife Piotr had also been diagnosed with schizophrenia in 2008, although this was never confirmed by Health professionals in the UK. Piotr had been prescribed medication which, according to his wife, he continued to receive from Poland. Piotr did not see a doctor in England.

14.4 Filip was described by his mother as being a sweet and pleasant child as he grew up. His behaviour had however changed when he started to misuse illegal drugs and in particular cannabis. This behaviour had started when he came to England and his Education records (2017) document a number of episodes whilst he was at school where he had been had been caught smoking cannabis. When smoking cannabis, he was described as becoming vacant and detached. His parents also noted a gradual but noticeable decline in his mental health from that time. Due to the deterioration in his behaviour his family made the decision for his girlfriend to come across to the UK to support Filip.

14.5 The family had a number of contacts with the GP surgery about other related health issues but they made no mention of the issues that they were having with Filip. Filip had not displayed any signs of psychosis while attending appointments in the GP surgery and there was nothing to suggest that he was having any relationship issues with either his father or his mother.

14.6 Whilst misusing cannabis Filip would become obsessed about his health, with his mother claiming that he had become involved with drug dealers (although this has never been verified). At that time Filip went to extreme lengths to obtain money in order to buy growth hormones. His father stated that Filip had been taking enhancement products in an attempt to increase his muscle mass and improve his physique. Filip had stated to his parents that he thought that this would give him the 'respect that he deserved'.

14.7 Filip's relationship with his father was described by Piotr's wife as generally good. In September 2020 Filip had however started to become aggressive. His family stated that he would cause arguments, would 'tussle' with Piotr and they would call each other names. Filip also started to call his mother names. Piotr would try to pacify Filip and attempt to make things better but had stated that he had reached the stage where he was at a loss as to what to do with his son.

14.8 Filip's girlfriend had also become concerned about his behaviour towards her. He would be verbally abusive and there were incidents where he told his girlfriend to go

back to Poland. He also swore at her, accused her of cheating on him and had told her that he hated her and that she was a bad person. On one occasion he had locked her out of the house and in a shed. Filip's girlfriend had stated that after he had these episodes he was unable to remember them and she described him as having a 'split personality'.

14.9 Filip's girlfriend had later recalled to the Police that when Filip had got an idea in his head he would twist it and make up his own version. There was an incident where Filip started calling his girlfriend a bitch and threw her suitcase out of the house (although this was never reported to agencies). Filip had also apparently taken a mobile phone from his girlfriend and had tried to choke her by grabbing her throat. Following Piotr's' death, Filip's girlfriend told Police that she was continually frightened at that time. Filip had also accused his father of abusing his girlfriend. Both Piotr and his wife stated that there was no truth in this allegation.

14.10 Filip's relationship with his parents had also deteriorated and they had admitted to agencies that they were struggling to cope. Filip had told professionals that he had been hearing voices and had stated that he was frightened because he believed that someone wanted to kill him. Health records show that he also believed that his parents were trying to kill him.

14.11 In total the Police attended four incidents of reported abuse at the family's home address. On one such occasion (3rd November 2020) they took Filip to the hospital. Filip was later transferred to a psychiatric ward and then moved to a psychiatric hospital where he stayed for six weeks. Whilst detained in hospital Filip was diagnosed with 'Mental and Behavioural Disorders due to use of cannabinoids and Unspecified Non-Organic Psychosis'. His mother informed the review that neither her, nor her husband. were aware of this diagnosis until after the court case.

14.12 Prior to Filip's hospital admission Piotr had told his wife that his son had accused him of molesting his girlfriend.

14.13 A week before Filip was discharged from the hospital he had spoken to his girlfriend on the phone. During that conversation he had accused her of sleeping with Piotr. The two of them had argued and she had stated that she should leave the family home, which she then did. Although she had moved out, Filip's girlfriend would return to the address and would occasionally stay at weekends.

14.14 When Filip was discharged from hospital he did not smoke cannabis for approximately one and a half months but his parents reported that he had started misusing the substance again after that time. As on previous occasions Filip's behaviour changed and he became distant and he would not talk to his family. His mother later recalled that his whole demeanor would change and his eyes would 'turn black' when he became aggressive.

14.15 In March 2021 Filip found employment but he was dismissed after two to three days, He then secured a second job but again this only lasted a day. In mid-March he was

able to secure a job for the same organisation who also employed his mother and girlfriend. In the first week Filip had an argument with one of the managers. In his second week Filip worked in the same section as his mother. During that time she noticed that he could not complete his work, would get distracted, and he would forget what he was doing. Filip would then walk off and start doing something else. Again Filip was dismissed from this organisation due to his unreliability. At the time of his dismissal Filip was described as being agitated and his family state that he did not take the dismissal well.

14.16 After Filip had lost his job his family state that he felt hopeless and he would sleep all day. He had also asked his mother to pray for him and his family describe his behaviour at that time as “unusual”. Filip’s mother had taken a week off to support her son during this period.

14.17 In the week leading up to Piotr’s death his wife described to the Police how Filip had become verbally abusive towards her, calling her a ‘slag’ and accusing her of cheating. This happened for three days in a row.

14.18 On the Saturday before Piotr’s death, Filip was seen by a Health professional, at his home address. Filip appeared to resent this as he thought he would have to go back to hospital. After this appointment he continued to drink excessively and at that point he was drinking eight to ten cans of beer a day. He was also failing to take his medication as it was prescribed. Filip continued to be aggressive and told his girlfriend and parents that he blamed them for his admission into hospital. Filip felt that they had ‘wanted to get rid of him’. Filip’s girlfriend later recalled to the police that Filip did not think that there was anything wrong with him. The family have since told agencies that Filip had become increasingly distant and had remained in his bedroom for increasing periods of time in the days leading up to Piotr’s death.

14.19 On the day prior to his father’s death Filip had received his monthly injection at his home address. He also took his diazepam and drank two beers. Filip then stated that he was going to bed as he felt unwell. Filip then slept most of the day. Filip’s girlfriend described how he spent the rest of the day in his bedroom either sleeping or pacing up and down. During the period he would also suddenly kneel and pray. His girlfriend recalled that he looked like he had flu, he had a temperature, and that he was weak and tired.

14.20 Later that same day Filip violently attacked his father whilst he was sleeping in his bed.

15.0 Analysis

15.1 This part of the overview will examine how and why events occurred. The analysis section seeks to address the terms of reference and the key lines of enquiry within them. It is also where any examples of good practice are highlighted.

15.2 This analysis considers the previous sections within this report and the content of the chronology of events. The information obtained from the investigation into Piotr's death has also been used in this analysis.

15.3 **Domestic Abuse**

15.3.1 The first area for analysis was to determine the nature and extent of abuse that was taking place within the household and whether Piotr had been subjected to abusive and/or coercive or controlling behaviour by his son.

15.3.2 There is little known about Piotr's childhood or wider family circumstances. There has been nothing found during the review or from the interview with his wife to suggest that he had experienced domestic abuse in his childhood.

15.3.3 From the interview with Piotr's wife it was apparent that there was no violence or abuse in the family. The review was unable to determine whether Filip's girlfriend had experienced domestic abuse in her life.

15.3.4 Agency records contained no information that would suggest that Filip had been violent or abusive (which is commonly termed as adolescent to parent violence and abuse (APVA)) [13] to either of his parents whilst he was growing up.

15.3.5 In this case all four adults had claimed that they had been subjected to abuse and although they had reported a number of incidents to the police the true extent of what was happening at home was difficult for agencies to determine. Often the information presented to agencies by Piotr and the other family members would vary in in relation to the nature and extent of abuse that was occurring in the household. National research has shown that domestic abuse is often underreported[14] and the extent and risk can be minimised by those reporting such issues[15]. In this case the family were very private and there was minimal contact with others outside of their own family circle.

15.3.6 The abuse perpetrated by Filip appeared to have started suddenly and appeared to be directly linked to the decline in his mental health. His behaviour had escalated to an extent that Piotr had felt it necessary to report the matter to the Police and other services. Research has shown that it is often difficult for parents to initially recognise unhealthy changes in the behaviour of their children and to acknowledge abuse as it 'suddenly creeps up on them'[16]. In this case it would appear that the family were initially trying to manage these changes by themselves but they had reached a point where in their own words, they were "unable to cope". Piotr and his family were proud and private people and for them to have sought assistance from partnership services must have been a significant step.

15.3.7 Piotr's wife has stated that they were unsure about who to contact to provide them with assistance. She believed that Piotr had looked on the internet for information but on

[13] Condry and Miles (2012; 2015), Coogan, D (2018).
[14] On average victim's experience fifty incidents of abuse before getting effective help (Safe Lives ;2018)
[15] Gibson 2019
[16] Bonnick, H (2019)

reflection she stated that it was not clear about what they should do or which services were there to assist them. The Vesta representative has highlighted that for many individuals who originate from outside of the UK there can be a general mistrust of services and that the information that is available to them is limited particularly in relation to domestic abuse services. Whilst this was not the case for this family, they were unaware of what was available to them in terms of mental health and domestic abuse support.

15.3.8 From the information that is available from agency records it is clear that Filip was abusive, controlling and coercive[17] in his relationship with his girlfriend and parents. The Cross-Government definition of domestic abuse and abuse[18] outlines controlling or coercive behaviour as follows;

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

15.3.9 The components of coercive control can include the behavioural traits which were shown in this case and which included:

- Deliberate use of alternative moods (although it is accepted that this could also have also been attributable on occasions to the decline in his mental health).
- Excessive jealousy and possessiveness.
- The use of threats, humiliation and intimidation.

Controlling and coercive behaviour is known to be a key marker for fatal domestic violence[19] which is why it is an integral part of the DASH[20] risk assessment process.

15.3.10 There were three incidents of domestic abuse recorded by the police in relation to the family. The first recorded incident occurred in the June of 2020. On this occasion officers completed a DASH assessment with Piotr as the victim and Filip as the perpetrator in line with policy. The DASH assessment was classified as 'standard'. This assessment would appear to be proportionate in the light of the disclosures that were made at that time. On this occasion whilst correctly recording the domestic abuse incident, the officers did, however, fail to follow their Forces' policy in terms of completing a BRAG[21] assessment. This process is used to identify any other vulnerable person, including children, at the scene (i.e. Filip). Despite a failure to

[17] Controlling or Coercive Behaviour in Intimate or Family Relationship Statutory Guidance Framework; Dec 2015; Home Office
[18] Domestic abuse; Home Office (2016)
[19] Myhill, A and Hohl, K (2016)
[20] DASH – Domestic Abuse, Stalking and Harassment and Honour-based abuse Toolkit. A nationally implemented took used to assess victim risk in cases of domestic abuse. It enables officers to assess the risk of serious harm to the victim to support safeguarding decisions. Ideally the completion of the DASH assessment will be victim-led but it can be completed by the officer alone based on their perception of the level of risk based on what is known about the victim and the perpetrator.
[21] BRAG Tool **–** A tool introduced in 2018 to objectively risk assess and record all forms of vulnerability or safeguarding concerns. The outcome of the BRAG assessments helps determine immediate action as well as helping LSU to triage and signpost or refer to appropriate partner agencies. It should be used alongside other assessment tools (such as the DASH), and its use is subject to continual compliance monitoring via the Qliksense App.

complete this form appropriate referrals were made to Children's Services. This should be seen as good practice.

15.3.11 Piotr and his wife had informed the officers about their concerns for Filip's mental state, which was in their view being affected by his use of cannabis and alcohol. These concerns were documented by the officers on the DASH form. The misuse of such substances is seen as a major risk factor for increasing levels of abuse and violence[22]. There is also research[23] that substance abuse coupled with mental health issues also increases the risk of domestic abuse and officers would appear to have been cognisant of these facts in terms of completing the DASH.

15.3.12 Despite the Police making the referral to CAMHS the Police IMR writer has acknowledged that, currently, the Force has no direct referral pathway to Mental Health Services or to substance misuse services where no crime has been recorded. Had this been in place, this would have assisted the family, and enabled officers to signpost them to the most appropriate agency to meet their son's needs. The current referral process for those with complex needs should be reviewed, in order for these vulnerable groups to be effectively supported by agencies (**Recommendation: 1**).

15.3.13 On the 24th October 2020 Filip attended an E.D on two occasions one of which was prompted by a call from his father. Piotr had called an ambulance after Filip had produced a knife (this had not been witnessed by Piotr's wife) and was being increasingly aggressive to his mother and his girlfriend. He also stated that he had "put his girlfriend in the shed' and he also stated that Filip had taken hold of a knife and was "grabbing [his] girlfriend by neck, threatening and aggressive". Filip was alleging that his father had hurt him. Health staff questioned Piotr about this and he stated that he had also called the police. Health records documented that the police had asked paramedics to attend the incident due to issues of psychosis and mental capacity but this is not reflected in their [police] records. This confusion had meant that the police were unaware of the incident until the following day.

15.3.14 On the 25th October 2020 Police had attended the home address to conduct a welfare check after Filip had been reported as missing by the hospital. Records show that Piotr did not make any further complaint about the alleged abuse incident that had led to Filip being taken to the hospital on the previous day. Police records show that they were aware of the allegation that Filip had assaulted his girlfriend and threatened his father with a knife. Despite this information being available it is unclear from the records whether officers highlighted the options that were available for Piotr or Filip's girlfriend to pursue the complaint against Filip. This was a missed opportunity to identify the nature and extent of the abuse that was occurring in the family.

15.3.15 In terms of the incident reported to the Police on the 27th October 2020 the officers who had attended the address spoke to all of the adults who had been involved. On

[22] Gibbs et al (2020)
[23] Gadd et al (2019), SafeLives (2019)

that occasion Filip did not want to make a complaint against his mother. The officers also spoke separately to Piotr's wife with the assistance of language line. Piotr's wife confirmed that she had not been harmed. Piotr and his wife both claimed that their son had become aggressive towards her and was shouting. Piotr's wife stated that she had become 'scared' of her son and had slapped him in the face. This assault was described by officers as a 'pre-emptive strike'.

15.3.16 The Police Force has adopted the College of Policing Authorised Professional Practice guidance regarding Adolescent to Parent Violence and Abuse (APVA)[24] into its Domestic Abuse procedural guidance. This guidance states that officers should recognise APVA as domestic abuse and investigate, risk assess and safety plan as for any other domestic abuse incident. The procedures also provide additional guidance where the abuse involves a sixteen or seventeen year old as either a victim or perpetrator **(Recommendation 2)**. Officers spoke to all parties involved in accordance with the policy. When an officer spoke to Filip's girlfriend she stated that he was very aggressive and was always angry. Filip's girlfriend told officers that two days previously Filip had grabbed her by the neck although she did not want to make a complaint or provide any further details.

15.3.17 Neither his mother, nor his girlfriend, wanted to pursue any further complaint against Filip for his aggression towards them. The officers at the scene decided that an arrest of his mother was unwarranted as the assault was minor and had been in response to his aggression. As no complaint was forthcoming they made a decision that an arrest would not assist the family at this stage. The officers established that Piotr and his wife were already in contact with the Crisis Team but wanted further help to obtain a mental health assessment for Filip. Officers provided safety advice to all of the adults in the household and in relation to his girlfriend they suggested that she consider living elsewhere until Filip had obtained additional mental health support.

15.3.18 The officers who had attended the scene also had the option to obtaining advice from a Mental Health Tactical Advisor (MH-TAC). MH-TAC are officers who have received specialist mental health training and can provide support to officers at the scene when dealing with individuals like Filip. On this occasion the officers sought advice from a Sergeant but not from a MH-TAC. Due to Filip's demeanour the officers felt that such an approach was not warranted. There is nothing to suggest that had the officers sought advice from Mental Health Services any different advice would have been given. On review the officers provided safety advice and completed DASH forms for both Piotr and his wife. The risk at that time was considered to be 'high'. Officers also completed a BRAG assessment. The officers recorded that Piotr wanted further support from the mental health teams as he was concerned that Filip could harm his family if his mental health deteriorated further. Despite there being no recognised pathway the Police made a referral to the Mental

[24] APVA Adolescent to Parent Violence and Abuse records that in a study across one year by the Metropolitan Police adolescents reported to the police were overwhelmingly male (87.3%) and that the parent victims were overwhelming female (77.5%). The officers in attendance needed to be perceptive to this and to the fact that this report was likely to be the tip of the iceberg given the vast underreporting by parents of APVA.

Health Team to ensure that they were aware of the family's needs and the potential for escalation. This should be seen as good practice.

15.3.19 On this occasion the officers completed a DASH risk assessment for all of the family members. The DASH recorded that Filip was a risk to his mother, father, and his girlfriend and officers made the comment that he had also tried '*to control his partner'*. The risk assessment was graded as 'High' with additional comments being included which stated;

"*His parents are concerned that he suffers with psychosis and are scared that he could harm them or his partner*".

15.3.20 On reflection the Police IMR writer identified that additional action could have been considered by the officers attending the address as documented in the APVA Guidance namely that a referral could have been made via the LSU to Community or Neighbourhood staff. This would have ensured that the family were contacted by a local beat officer, or community support officer to conduct a further welfare check and they could have been signposted to other support agencies.

15.3.21 A referral should have also been made at that time to MARAC due to the increased risks that were identified by the officers. The review was unable to ascertain why this had not occurred as policy and procedures are in place for this to occur. This was a missed opportunity in terms of all partners being able to share information, review of the risks and implement an action plan. The family should have also been signposted to appropriate domestic abuse agencies for help and support.

15.3.22 There were also discrepancies in the information exchanged and held by agencies. EI records (27/10/20) record that 'the Police believe [that] he does not pose a risk to others' and yet the completion of the DASH demonstrated otherwise and there were entries alluding to Filip stabbing his father. This would appear to have been never followed up and again was an opportunity that had been missed to take positive action and mitigate the escalating risks to the family.

15.3.23 The Police did take positive action on the 3rd November 2020. All of the adults in the household were spoken to and both Piotr and his wife declined to make a complaint. His mother later stated that they simply wanted medical help for their son. On that occasion Piotr had initially acted as an interpreter for his wife as officers state that he had a good command of English. Body worn cameras were also worn by the officers in order to capture any evidence of offences. This should be seen as best practice.

15.3.24 On that occasion Filip's girlfriend had declined a DASH. The officer completed the form stated;

"*Domestic issues have arisen due to Filip believing his girlfriend and father are in an intimate relationship…. This event has resulted in him grabbing her by the*

throat. I am unaware of previous issues. Victim declined DASH at the time but I will attend and check again."

15.3.25 The assessment at that time was graded as medium. Later a Polish speaking officer (which should be seen as best practice) had spoken to Filip's girlfriend alone but she had again declined to complete the DASH (see section 15.5).

15.3.26 The repeated attempts to obtain a statement of complaint should also be seen as good practice. Despite these attempts Filip's girlfriend declined at that time to support a prosecution. The reasons for that decision were not recorded. Research shows that victims of abuse can decline to support a prosecution due to a variety of factors including the fear of increased abuse, mistrust of authorities, family and partner loyalty and the influence of those individuals engaging in abusive behaviour through coercive control[25]. In this case his parents did not want to criminalise him as they recognised that he was suffering from a mental illness. Despite a lack of a compliant the Police did however take positive action and Filip was arrested for the assault.

15.3.27 The body worn video recordings from officers who had attended this incident and the custody record were reviewed by a mental health co-ordinator as part of the IMR process. The outcome of this review was that the police officers acted in accordance with the Forces' domestic abuse policy when attending this incident and that the custody arrangements made for Filip and the use of the Mental Health Act in his detention were proportionate and appropriate. The Police also considered a victimless prosecution but on review the decision was made that there was insufficient evidence to progress the case.

15.3.28 Piotr's wife has identified that her and her husband had considered the Police as being the main agency able to help them whilst in the community. She stated that officers had explained to them that there was little that they could do in terms of positive action due to the fact that her son was suffering from mental health issues. She stated that they had also stated that current laws and the circumstances of the incident meant that they had no power to act. From the discussion with her it was clear that she and her husband had found this confusing, and that whilst this may have been correct in terms of the powers that they have under the mental Health Act, this had not been sufficiently or clearly explained to them. Piotr's wife stated that they felt that the Police were questioning their ability as parents and they were made to feel that most people would not call the Police for such matters.

15.3.29 Piotr's wife also claimed that they had also not been informed of their options in terms of additional support or personally signposted to agencies that could help them. This left them feeling isolated and unsure about who to contact should their son's behaviour deteriorate further. The Police IMR records detail a different recollection of the events and the way that officers dealt with the couple. What is

[25] Farmer E, Callen S (2012); Barrow-Grint (2016)

apparent is that there were clear communication barriers in terms of providing the help and support the family needed.

15.3.30 In terms of what was known to Health, there were no specific concerns of domestic abuse recorded in hospital or GP records in relation to Piotr or Filip prior to the incident on the 24th October 2020. Despite the disclosures[26] that were made on that date, those Health professionals who came into contact with Filip failed to recognise him as being either a perpetrator, or a victim of abuse, and never explored this with him or his family.

15.3.31 There was also a lack of professional curiosity in relation to the reported volatile and aggressive actions towards his girlfriend. Whilst at hospital on the 24th October 2020 hospital records state that Filip had locked his girlfriend in a toilet. Again these allegations, although known, do not appear to have been explored further or considered as possible domestic abuse.

15.3.32 A further opportunity to explore the family dynamics presented itself in December 2020 when Filip was admitted to hospital. On that occasion Filip reported that there were 'issues with [his] family'. Those dealing with Filip did not explore this comment further with him or seek his views about his relationship with his parents and girlfriend.

15.3.33 Filip had demonstrated that he was capable of inflicting serious harm[27]. Piotr had stated, later that same evening on the 24th October 2020, that his son had used a knife to threaten his father and had grabbed his girlfriend around the neck choking her. Staff would appear to have relied on the fact that Piotr had stated that he had contacted the Police during Filip's earlier presentation to hospital. Whilst it is acknowledged that staff members were dealing with Filip's mental health crisis at that time, this escalation in abuse could have led Health professionals to believe that there was an imminent risk of serious harm to family members and the police could have been contacted. This would have ensured that there was an effective multi agency approach. Records fail to show whether this was even considered of if attempts were made to persuade his family to initiate such contact.

15.3.34 Hospital records also failed to capture his mother's voice and there would appear to have been little consideration of her needs and the impact on her in terms of her sons behaviour. At that time staff were working in a challenging ED environment and whilst an in depth exploration/ assessment of the family circumstances may not have been possible, this was an opportunity for staff to explore the immediate risks. Completion of a HEEADSSS/ Mental Health Matrix would have provided ED with the appropriate framework to support them in this process.

15.3.35 The failure to effectively engage with Filip's parents and his girlfriend were missed opportunities in terms of exploring the family circumstances and the abuse that was

[26] Piotr had on one occasion stated to hospital staff that Filip had made allegations against him for harming him but this was not explored further by staff.

[27] The Home Office definition of serious harm is 'A risk which is life threatening and/or traumatic, and from which recovery, whether physical or psychological, can be expected to be difficult or impossible.' In this case the potential event was more likely than not to happen imminently and the impact would have been serious.

occurring. Had professionals also used the THINK FAMILY[28] approach in their work then they would have gained a greater awareness of all of the issues faced by those in the household. Such an approach would have also established the context and levels of risk in the home and the possible triggers to mental health deterioration. Had professionals been curious then there would have also been increased opportunities for the family to make disclosures. Professional curiosity, the 'THINK FAMILY' approach, and the use of routine enquiry[29] by Health services must be promoted within GP and A&E services in North Somerset (**Recommendation 3/4**).

15.3.36 There appeared to be good consideration by AWP staff of the risks to Filip's girlfriend following the incident of reported strangulation on the 3rd November 2020. This triggered staff to contact the Police and to enquire about what safeguarding measures had been taken by them following the incident. The incident also prompted staff to contact his girlfriend and according to Mental Health records to complete a DASH risk assessment. Although the DASH was recorded in English it had been completed by a Polish speaking member of AWP staff. This should be seen as good practice.

15.3.37 The review identified that records show that a DASH and MARAC referral form had been completed by staff at the secure unit, run by AWP, and uploaded onto Filip's record. Those completing the DASH concluded that the risks to the family at that time were 'high'. There was however some confusion about whether the forms had been fully completed and a referral made. This had been evident during a conversation between staff on the psychiatric unit and the police on the 23rd November 2020. At that time staff on the Unit were seeking to identify all of the risks prior to Filip being discharged but were unable to verify whether the MARAC referral had been completed. Action could have been taken to address this issue and clarify whether the referral had been made in accordance with policy. It was unclear from records as to whether systems pressures at that time prevented this from occurring or whether it was an omission by a specific individual.

15.3.38 On review the AWP Trust's Safeguarding Team were unable to find any record of the MARAC referral being made. There was also a failure to complete and submit an incident form relating to the MARAC referral. This should have been recorded on the Trust's adverse incident reporting system in line with their procedure. Checks were also made with both the Bristol and the North Somerset MARAC and neither had received the referral. There was a clear recognition by the Panel that a MARAC referral should have been submitted to Next Link.

15.3.39 There were also several occasions where the electronic record entries that were made by Mental Health staff, from the AWP Trust, were not validated (including the one relating to the DASH risk assessment). Validating records on the Trusts' Rio[30]

[28] Think Family is an approach to help practitioners consider the. parent, the child and the family as a whole when assessing the needs of and planning care packages with a individuals suffering from a mental health problem.
[29] NICE (2016) Quality Statement 1 states that 'People presenting to frontline staff with indicators of possible domestic violence or abuse are asked about their experiences in a private discussion'.
[30] RiO - Information about patients is inputted and stored on an electronic patient record system called RiO.

system acts as a signature to confirm that the entry has been completed and that the record is a true account of the action that has been taken **(Recommendation 5).**

15.3.40 Accurate record keeping was a particular issue that was identified in this case and had led to several omissions in practice. Had the referrals been made then the MARAC process would have provided holistic oversight of the case and additional safety measures could have been considered by the multi-agency panel, including specialist domestic abuse support for all of the family members. Both Piotr, his wife and his girlfriend could have also been signposted to other services suitable to meet their needs as Polish internationals.

15.3.41 In North Somerset all MARAC referrals are channelled through 'Next Link' who are commissioned to support the administration process. The staff in Next Link then assess the referrals and ensure they meet a specified criteria before the case is listed for the next available MARAC meeting. A score of over fourteen on a DASH risk assessment would trigger a referral as it would be considered to be high risk.

15.3.42 Agencies can also use their professional judgement in referring cases where the circumstances lead them to believe that there are high risk concerns. In this case there were two occasions (Health and Police) where the DASH risk assessment identified high risk behaviours and yet these failed to trigger the MARAC process.

15.3.43 Agencies reviewing this case were unable to identify why this hadn't occurred and those on the Panel believed them to be isolated incidents. All agencies confirmed that the current referral system is robust and this incident was likely to have been down to human error rather than a 'systems issue'. The Police together with North Somerset Partnership are currently reviewing the MARAC process to improve its effectiveness and this case should be considered as part of that learning process **(Recommendation 6).**

15.3.44 Whilst some Health staff, at both UHBW sites and within AWP, had considered the risks to Filip's girlfriend in terms of domestic abuse they had failed to apply the same thinking to his parents. There was also a failure to signpost them to domestic abuse support services, for example the local Nextlink[31] provision. The IMR writer from AWP was unable to ascertain why this hadn't occurred in their own organisation, but surmised that it could possibly be due to the context of the relationship falling outside intimate partner abuse. The AWP Trust's Domestic Abuse Procedure provides a definition of domestic abuse which encompasses both 'intimate partners and/or family members' and therefore staff should have been familiar with this and the risks identified **(Recommendation 7).** Whilst this issue was raised in respect of Health it is apparent that APVA needs to be integrated into the domestic violence framework and strategy in North Somerset to ensure that staff in all agencies recognise such abuse and deal with it appropriately **(Recommendation 8)**.

[31] Nextlink provides specialist advice and support for victims of domestic abuse.

15.3.45 In addition to the one that has been previously mentioned at section 15.3.34 there were other missed opportunities by AWP Mental Health staff to complete a DASH assessment with Piotr and his wife. Such an assessment could have been completed by the Early Intervention Psychosis team when Filip was an inpatient and by the Intensive Team following his discharge (when his parents were reporting a deterioration in his presentation). The failure to identify the reported issues as domestic abuse meant that support service information was not offered to his parents.

15.3.46 Since April 2021 there has been AWP Trust wide domestic abuse training programme offered to staff. This training focuses on high risk cluster behaviours and the eight steps to homicide[32]. There is also a particular focus on using professional judgement on cases involving individuals outside the intimate partner dyad. AWP have also identified that they can further strengthen these areas of good practice through the development of a directory of services to support staff when dealing with incidents of domestic abuse **(Recommendation 9)**.

15.3.47 Whilst Filip was receiving treatment in relation to his mental health there would appear to have been little consideration of how to manage his risk in terms of abusive behaviour. In this case agencies did not identify and address the pattern of coercive and controlling behaviour exhibited by Filip. The importance of clear and consistent pathways to help victims and individuals engaging in abusive behaviour cannot be underestimated[33]. At present such pathways are extremely limited in North Somerset but are being considered as part of their current Domestic Abuse Strategy. Those developing and implementing the strategy will need to be cognisant of the complexities of the needs, and risks[34] of non-English speaking groups. and that to be effective they may need to be delivered in their native language **(Recommendation 10)**.

15.3.48 The true extent of the impact of Filip's abusive behaviour in relation to his parents and to his girlfriend was not fully understood until after the death of Piotr. The subsequent Police investigation was able to ascertain that the levels of verbal abuse had been excessive in the weeks leading up to his father's death and that this had gone unreported. Filip's mother has been able to verify that her son was not physically aggressive towards her and that he would 'push' his father about rather than attack him.

15.4 **Mental Health/Safeguarding Practice**

15.4.1 Mental health is a significant issue in homicides and is recorded as the second most common health-related theme in the DHR reports.[35]. In Filip's case he had been separated from his girlfriend when he moved to the UK in June 2016. This move would

[32] Monkton- Smith (2021)
[33] Iriss (2020)
[34] Suicide rates of Polish men in Scotland are significantly higher than Scottish men – 31.5 vs 19.4. Factors contributing to suicides among Polish men included employment status, financial status, healthcare access, alcohol and substances misuse, relationships, police and legal involvement (Gorman at all, 2018). Between 2011-18 5 out of 12 Polish prisoners convicted for domestic violence cases killed themselves. Poland has the highest levels of familicides involving partner and children in Europe (Matusiak, 2019)
[35] Sharp-Jeffs and Kelly (2016)

appear to have had a detrimental impact on his wellbeing as he felt isolated and resentful. Child who are subjected to migration (albeit in this case by the wishes of his parents) can be more vulnerable in terms of their physical and psychological wellbeing. They can also develop behavioural issues such as sleep disturbances, anxiety, depression and engage in violent behaviour and self-harm[36]. In this case the true impact on Filip by the move to the UK couldn't be accurately determined but from the conversations with his mother it was apparent that he had found this part of his life unsettling.

15.4.2 Filip's condition had also deteriorated further due to the use of cannabis and alcohol and the effects of him being isolated through COVID. These factors had led to a sudden and unexpected deterioration in his mental health.

15.4.3 Between 2018 and early 2020 Filip had attended hospital on four occasions. When in crisis Filip presented to the E.D. at both the hospital sites managed by the acute NHS Trust (UHBW). There were no specific medical needs identified at each of these presentations but clear mental health concerns were recorded in all of the contacts that he had with staff.

15.4.4 The first reported concerns of mental health were identified on the 24th October 2020 when Filip and his father attended the accident and emergency department of one of the UHBW hospitals in North Somerset. When Filip first presented to Hospital 1 (24/10/20) established processes were not followed in relation to child or adult protection procedures.

15.4.5 There was no evidence that staff had considered any wider safeguarding risks including the possibility of whether other children were present at the home address. The name and age of Filip's girlfriend was also never recorded in Health records and there was no attempt to identify whether she was vulnerable. Due to Filip's age at that time professionals failed to recognise that she too could have potentially been a child and therefore relevant referrals to Children's Social Care would have needed to have been be made **(Recommendation 11/12)**.

15.4.6 Filip's presentation occurred on a Saturday and at that time there would have been no access to the safeguarding team due to the hours that they work, and yet there are established procedures in place for such an occurrence including information about how to access support from Emergency Duty or Mental health teams. In Filip's case there were no records that the out of hours teams (Child and Adult Mental Health Service (CAMHS)) were called for mental health support or for them to complete an urgent assessment. There was also no documentation indicating that the Emergency Duty Team were contacted for safeguarding advice or a referral made to Children's Social Services **(Recommendation 13)**.

15.4.7 There was also no evidence that the UHBW acute care NHS Trust Mental Health Matrix (which includes safeguarding considerations) was completed in either of the

[36] Mindlis I (2017)

Emergency departments. The Matrix is used to ascertain the level of risk and the mental health support required for any patient attending the E. D with a mental health presentation[37]. The Matrix could also have resulted in the consideration of a Section 136[38] to remove Filip to a place of safety for an urgent Mental Health Act assessment to take place. Where patients such as Filip leave the departments without risk assessments being performed a senior clinician must be informed so that they can consider the need to share information with appropriate agencies, relevant to the risk. This practice did not take place in this case although the review has been unable to ascertain why this did not occur **(Recommendation 14)**.

15.4.8 There was also no inclusion of the HEEADSSS assessment in either of the emergency departments. This assessment focuses on the young person's perspectives on their life and includes details relating to such issues as home, education/employment, eating, activities, drugs, suicide, sexuality and safety. The AWP IMR writer has identified that it is possible that if Filip had been risk assessed then several issues of concern may have been exposed. Had this action taken place then this may have demonstrated a sufficient level of risk to have triggered an urgent referral for assessment by the CAMHS team. The completion of the HEEADSSS may have promoted staff to make a safeguarding referral. **(Recommendation 15)**.

15.4.9 In terms of safeguarding procedures staff at both of the UHBW hospital sites didn't consider whether there was a need for Mental Capacity Act[39] (MCA) Assessments to be completed on the two occasions that Filip discharged himself. Under the MCA you are required to make an assessment of capacity[40] before carrying out any care or treatment if you have reasonable belief that someone may lack mental capacity due to an impairment of mind or brain (MCA 2015). In this case the extent of Filip's capacity was not known although it was clear that there were concerns about his mental health. In Filip's case it would appear that there was an assumption that he had capacity to make decisions in terms of his treatment. Filip was also not asked for his consent to share information which could have hindered the delivery of services to him in terms of multi-agency support. There were clear procedures in place at that time which covered this aspect of his care, although why they weren't followed is unclear **(Recommendation 16)**.

15.4.10 CAMHS had also intended to raise a safeguarding referral to Children's Services on the 30th October 2020 but there are no records that this was actually made. Again there has been nothing identified in the review to explain why this had not occurred as there are clear procedures and processes in place.

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[37] If the person is considered "red" on the matrix, it will trigger an urgent referral to mental health teams, "amber" means the person is considered safe for the mental health team to review at the start of the next day and a "green" result would indicate someone is safe to discharge with either primary care follow up or signposting to relevant services.

[38] Section 136 is part of the Mental Health Act 1983 that gives police emergency powers. Police can use these powers if they think you have a mental disorder, you're in a public place and need immediate help. Section 136 says police must think you need immediate 'care or control'.

[39] Mental Capacity Act 2005

[40] Capacity means the ability to use and understand information to make a decision, and communicate any decision made. A person lacks capacity if their mind is impaired or disturbed in some way, which means they're unable to make a decision at that time.

15.4.11 From the review of UHBW records it would appear that staff did not use a Polish speaking service to assist in the risk assessments that were initially carried out in the Emergency Departments. From the information held it would appear that staff used Piotr for that purpose. Whilst Piotr may have been initially used for expediency on the day, staff should have then accessed official interpreting services. The IMR writer from UHBW has confirmed that staff have access to such a service and should utilise it in all suitable cases **(Recommendation 17)**.

15.4.12 Whilst Filip's parents were involved in the risk assessment process that were carried out by UHBW Health professionals (i.e. 24/10/20) it is now clear that they did not understand the treatment and support options that were available to their son. Piotr's wife has confirmed that her and her husband were left confused and bewildered when they left each of the Health settings who were dealing with their son. She stated that no one actually explained and more importantly check that they understood what was happening to Filip, what his diagnosis was and what they could expect. On one occasion a nurse was trying to talk to Piotr's wife and was told by another nurse that this was pointless as she would not understand anyway due to her being Polish. Piotr's wife has a limited command of English and was able to understand the comments made about her. It is important that Health staff and other agencies are aware of the fact that people from non-English speaking communities may not fully understand symptoms of mental health illness[41] and the support that is available via the Health Service. In this case the family were severely disadvantaged due to language barriers and the inability of staff to access interpreters (this will be discussed further at section 15.5).

15.4.13 In terms of mitigating the risks and managing Filip in the community mental health trust professionals used a multi-agency Care Programme Approach (CPA) to plan for Filip's discharge on the 14th December 2020. Unfortunately there was nothing recorded in terms of the plan or the minutes concerning the wider safeguarding issues raised in this case. Filip's discharge summary asks;

'Is the service user at risk to themselves, others or both themselves and others?'

The entry states that this is not applicable which would either indicate that all the risks were not fully considered or that the discussions held within that meeting were not comprehensively recorded.

15.4.14 AWP Health professionals working with Filip and his family made the decision that having assessed the risks, that he should continue to be cared for by his family after his discharge. The IMR writer for AWP identified that they had made this decision as they believed that Piotr and his wife continued to want to support their son and that they wanted him to stay with them. Filip's' mother has since stated that there was no discussion with her or her husband, and they were unaware of his diagnosis at that time and the fact that he had been hearing voices. The Mental Health team supporting

[41] (SafeLives, 2019).

Filip felt that the Early Intervention Psychosis team was effectively monitoring his case and appropriately treating him. Later, following an internal referral, his case was also over seen by the Intensive team and it was felt that these arrangements were sufficient to prevent escalation. It is however, unclear from records whether staff had identified alternative options of care for him or whether these were discussed with his parents. If these options were discussed, they were not recorded within Health records.

15.4.15 Piotr's wife has stated that the family felt that their son had been let down by the Psychiatric Services and in their view those treating him had not listened to their concerns or treated his condition seriously. They felt that there were aspects of his care which they were dissatisfied with including issues about the supervision of his medication. His mother also stated that they were constantly being told that her son didn't have a mental health condition. She stated that it wasn't until she showed a psychiatrist a media clip recorded on her phone of her son having an 'episode' that it was taken seriously and medication was prescribed to manage his condition. There is nothing recorded in documentation that would indicate that these concerns were raised at the time, although, what is clear is that his parents were completely confused about the processes that had been put into place to treat their son. In his mums words they "felt helpless" and it was if the whole system was against them. She stated that her and her husband felt that the Health Services didn't care.

15.4.16 There has been nothing found by this review that would indicate that Filip's treatment was inappropriate but what is clear is that there were obvious breakdowns in the communication with Filip's family in explaining his diagnosis and what was happening to him. The family were seeking explanations to this unexplained behaviour but felt that they were marginalised by staff. Again, language barriers would appear to have been a factor.

15.4.17 The family felt that they had no choice but to care for their son following his discharge. They stated that they had received a call from Filip on the day to collect him from the hospital where he had been detained, and that he exited the building on their arrival without any explanation as to what was expected of them or about his treatment. The family had believed that this was the system in the UK and that they thought that they may get correspondence at a later stage. The discharge procedure at the secure unit would appear to have been poorly co-ordinated with no full consultation with the family. This is poor practice.

15.4.18 In this case the risks were clear;

- Mental illness – Filip was paranoid and delusional (his father was a significant part of his paranoia in terms of him believing that he was having a relationship with his girlfriend).
- Propensity to be violent, including the strangulation of his girlfriend
- Filip had made an explicit threat to kill his father (03/11/20)
- Use and access to weapons. The choice of weapon described by Piotr as knives
- Drug/alcohol misuse

- Polish cultural differences mean that some families are unlikely to ask for help and yet in this case they were actively attempting to do so which should have triggered greater professional curiosity.

15.4.19 From the information that is held it would appear that these risks were never truly appreciated and action taken to mitigate them. If they had been considered then they should have been recorded. There was an over reliance on Filip's parents being able to deal with their son, despite the fact that they had previously reached out to agencies to ask for support with them stating that they were unable to cope with him. Filip did pose a clear risk to his family members particularly his father and his girlfriend and yet there would appear to have been no consideration to minimising this risk by taking proactive action, such as finding alternative housing provision for him.

15.4.20 There is no evidence that UHBW and AWP staff, had fully discussed safety planning with the family prior to his discharge, or that discussions had taken place about potential risk. There were opportunities to complete basic safety planning with Filip's family and his girlfriend following the incident where he was sectioned in November 2020 and following his discharge to the community. There were also opportunities to have these discussions with the family following Filip's discharge from the ward when tensions within the family dynamic were noted and there were possible signs of deterioration. There is no record in Rio that this was completed. His parents and his girlfriend's needs should have been looked at holistically and appropriate signposting and support offered.

15.4.21 There was a discussion between a care co-ordinator and the Early Intervention team on the 14th December 2020 about safeguarding concerns and family dynamics which resulted in a plan that would ensure regular contact with Filip. This care plan documented the Early Warning Signs and there was a crisis plan in place which provided contact details for his parents should they need additional help. Again this plan would appear to have not been fully explained to the family and their understanding checked.

15.4.22 Once this care plan had been established Filip had been receiving regular treatment both as an inpatient, and in the community, from the mental health team and a care co-ordinator. This engagement included regular one to one meetings with Filip and his family at their home address. Systemic family intervention[42] was also being considered but the family were described as being 'ambivalent' about this form of support and Filip had refused to attend such meetings. On reflection it would appear that the family were ambivalent as they were uncertain about the role that were required to take to assist their son in his recovery.

15.4.23 In April 2021 the Early Intervention Team made a referral to the Intensive service for support. The Intensive service provides increased support for individuals who are experiencing mental health crisis. The team stated that they had recognised the increased stressors in the home and acknowledged his parent's concerns about

[42] Therapeutic services involving the family with the goal of improving the mental health knowledge and well-being of all individuals concerned.

Filip's presentation. The AWP IMR writer identified that the assessment which proceeded the referral to the Intensive service was well documented and there was clear rational evident for decision making i.e. the documentation was clear that consideration for hospital admission had been considered, however they felt that this was unnecessary as Filip was compliant with his medication[43] and was agreeable to an increase in dose and that there was no sign of psychosis during the assessment.

15.4.24 The AWP IMR writer identified clear evidence that the mental health team was engaging with other agencies and that they had made attempts to encourage Filip to participate with the services that he was offered. There was also evidence of regular reviews being carried out and Filip's case being discussed at team meetings.

15.4.25 In terms of the care plans (AWP) that had been completed, there appeared to be an inconsistent approach in recording practices. There were some circumstances where care plans had been closed whilst on other occasions they had been updated and over written. This which meant that the details of the original care plan could not be reviewed and were not available to all appropriate staff.

15.4.26 The AWP inpatient unit has clear guidance for the completion and updating of care plans. Staff are required to finalise and close any out of date plans and create a new one so that they are clear, concise and previous care plans can be easily reviewed. There was evidence in some of the care plans that elements were 'to be discussed' with Filip. In these sections of the care plan it should have featured his comments and thoughts, however it was not clear whether or not they were discussed with Filip at a later date. It does not appear from the information documented, that Filip or his parents were always asked to provide an input into these care plans. Had they been fully consulted then Filip's family would have continued to articulate their concerns about his behaviour which caused them to lock him in the house to prevent his access to illicit drugs and alcohol. The review identified that there has not been any form of training for staff regarding the completion of care plans however this is currently in development as part of the AWP Trust Wide Quality Improvement programme **(Recommendation 18)**.

15.4.27 The review identified that the completion of basic safety planning was not featured in the AWP Trust's Domestic Abuse Procedure at the time of Filip's admission as a mental health inpatient. The Trust has since developed a Safety Planning Tool to support staff in the discussions with family about how to keep safe when they are victims of domestic abuse. This should be seen as good practice and AWP needs to ensure that it also meets the needs of non-English speaking communities.

15.4.28 The review also looked at whether Filip had been disadvantaged as he transitioned from child (CAMHS) to Adult Mental Health services. There is evidence in the records of clear communication and good links between CAMHS and the Early Intervention Psychosis (EI) team. Both teams shared information about the outcomes of assessment and risks. This should be seen as good practice.

[43] It was later identified as part of the Police Investigation that Filip's compliance was intermittent.

15.4.29 In terms of Filip's drugs misuse the Panel explored whether sufficient support had been given to him and his parents to assist him in overcoming his addiction. Filip was known to be using cannabis on a regular basis by agencies. His first recorded use was in 2017 when he was fourteen years of age. On this occasion his school had contacted the police and his parents after finding him smoking cannabis on their grounds. This matter was dealt with in accordance with ASC policies the ACPO[44] Youth Offender Case Disposal Gravity Factor System. Following consultation with the head teacher, Filip was excluded from the school pending a decision on whether he would be allowed to remain a student at the school. At that time Filip could have been referred onto the Drugs Education Programme[45] but this was not felt to be appropriate in the circumstances due to his age and level of misuse. This would appear to have been an proportionate response in the circumstances at that time.

15.4.30 The Panel did consider whether drugs and alcohol intervention programmes could have been introduced at an earlier stage in Filip's life and whether this could have prevented his behaviour from escalating and his mental health from deteriorating. There was no evidence found by the review that would suggest that even if he had qualified for such a programme that it would have prevented the periods of crisis in his life. His family had tried to refer him to such a treatment facility in Poland but they had been informed that he would need to consent to his admission to the facility. Filip refused to consent to this treatment. As a minimum Filip's family should have received information and been signposted to relevant agencies to assist in their management of their son.

15.4.31 Health professionals on the Panel did state that drugs intervention should have been a consideration in terms of his care plan. There were however no specific actions recorded to address this issue and from the multi-agency discussions held it was clear that there was a lack of clarity in terms of the pathways available for staff for drugs and alcohol referrals **(Recommendation 19)**. Health staff across all settings would appear to have concentrated purely on his presenting issue, which was his mental health.

15.4.32 The decline in Filip's mental health in the final days prior to him taking the life of his father was witnessed by his family but largely unseen by those who were supporting him in the community. Despite this decline there were no specific threats or identified risks in relation to his father. From the records that were reviewed as part of the DHR process and from the discussion with his mother it is apparent that no one could have foreseen the tragic events that occurred.

15.5 **The Polish Community**

15.5.1 As part of the review process contact was established with the Diverse Communities representative in North Somerset. The Polish Community is known to be the largest

[44] Association of Chief Police Officers – a national organisation made up of Chief Constables, Deputy Chief Constable and Assistant Chief Constables which recommends policy and standards for the Police Service in England and Wales
[45] Now the Youth Alcohol Drug Diversion scheme (YADD).

ethnic group in the County, although their exact numbers are not known. The true extent of abuse within the Polish community is difficult to determine due to current recording practices in relation to the way that agencies record nationalities. Numerous nationalities can be categorised under one generic term such as 'White European' and as a consequence some groups are completely hidden in official statistics. It is important that agencies accurately record nationalities in order that they can identify trends in domestic abuse and offer services that meet specific community and client needs. **(Recommendation 20/21)**.

15.5.2 The Panel recognised that attitudes and cultural differences for some non-English speaking nationalities, including the Polish community, can mean that there is little trust of mainstream services[46]. Such mistrust can often prevent individuals from reporting issues such as domestic abuse to the authorities and prevent them from seeking help[47]. In this case, there was no insight within agency records on whether cultural differences or language barriers, specifically in relation to Piotr's wife and girlfriend, could have affected the understanding of abuse and the risks posed by Filip.

15.5.3 There were opportunities to engage with the family despite the barriers experienced around language. Whilst there was evidence of good practice (Police) there were also opportunities to improve engagement with the family that were not capitalised on. At the end of March 2021 it is documented that Filip's father had requested that a Polish member of staff contact his wife as she wanted to speak to someone about Filip. Piotr's wife has since stated that her husband had asked for this help as he was concerned that due to work commitments he would not be available to accompany him to appointments. A member of staff spoke with Filip's father and advised that this request would be passed onto someone who would contact them. There is no documentation to suggest that this was followed up or whether indeed contact was made with his mother to discuss this further. Piotr's wife stated that despite repeated requests, the option of interpreting services was never provided. This was an opportunity that was missed.

15.5.4 AWP has a clear procedure that an interpreter should be provided when there is an identified need for both service users and their carers'. The review has been unable to establish why this hadn't occurred.

15.5.5 The Vesta representative on the Panel identified that non English speaking communities including some within the Polish community can often need far more support for practical issues such as health, housing and finance. Signposting to other services is often not enough and without effective interpreter services clients find it difficult to access or understand the support that they are offered. This means that victims are often unable to break the abuse cycle or have confidence in the services that are available to them. Such barriers can be overcome by ensuring that, where possible, domestic abuse support services have a workforce that either reflects the community that they serve or that they have access to effective interpreter services.

[46] Notes from Poland (2020)
[47] Notes from Poland (2020)

15.5.6 Interpreters need to be used not only in relation to those individuals where there is a language barrier but also in those cases where there are concerns and risks within the family set up. Without such assistance, risks may be minimised and information may be manipulated to protect family members. Research shows that access is pivotal in maintaining confidence in the system and with agencies. The lack of an interpreter can adversely impact on the outcomes of such cases and can allow individuals who are engaging in abusive behaviour to adversely influence a victim's decision in reporting such matters[48] **(Recommendation 22)**. Professionals should however be cognisant that the presence of the interpreter may still inhibit the full disclosure of information, due the client being uncomfortable in their presence, and the risk that they could be a member of their own community.

15.5.7 The use of interpreters in this case would have allowed all of the family members to talk in their first language. The ability to do this would have assisted in developing professional relationships and ensuring that the family members could feel more comfortable about discussing the issues that they faced. The provision of such services would have also assisted in promoting inclusion and ensure that a strengths based approach was adopted by agencies through open and constructive dialogue.

15.5.8 The availability of information for non-English speaking victims' living and working in North Somerset is at present variable. Whilst those on the Panel have stated that some agencies have addressed this issue others felt that the majority of literature that is available to professionals and victims is not inclusive and that work needs to take place to ensure that materials are translated for identified groups. The availability of multilingual literature across all agencies relating to domestic abuse services, mental health, drugs and alcohol support and therapeutic interventions was found to be variable **(Recommendation 23)**.

15.5.9 The Vesta representative on the Panel has highlighted that the North Somerset Partnership should review the current support groups that are available in the area for non-English speaking communities. Such a review would identify gaps in current service provision and support in the voluntary sector and enable additional work to take place to encourage the formation of such groups (**Recommendation 24)**.

15.6 Information governance issues

15.6.1 Effective recording issues and the ability to share information in this case was restricted by the fact that the relevant details that should have been available to Health staff at UHBW hospitals was not accessible in "real time". Such access would have shown the escalation of events and would have increased opportunities for partnership working. Effective information sharing would have enabled those working with the family to effectively plan, share concerns and agree risk management plans.

[48] Farmer E, Callen S (2012); Barrow-Grint (2016)

15.6.2 Following the merger of the two UHBW hospitals involved in this case (April 2020) the patient information systems across the sites are not yet compatible and information is not readily available to staff. At present the E.D staff on both UHBW Trust sites are unable to access mental health service (AWP) information systems. Information sharing is also reliant on mental health liaison teams on both sites accessing the AWP mental health records. Connecting the record systems would improve accessibility for staff and the ability for them to accurately assess risk **(Recommendation 25)**.

15.7 **Operational Practice/Policy**

15.7.1 The review identified that communication between AWP and Filip's health centre could be improved through the use of regular case conferences. Improvements have been made to overcome these issues. The Health Centre (GP) Mental Health Nurse and Support worker are now in regular contact with AWP. This nurse also attends regular meetings involving AWP, the police, Social Care and local schools to discuss high risk patients. This should be seen as best practice.

15.7.2 As part of his care plan Filip had access to a mobile phone provided that he used it 'appropriately'. On the 11th November 2020, whilst an inpatient in a secure mental health unit, it was identified that Filip had been reportedly calling emergency services on multiple occasions. This resulted in staff removing the phone from his pocket, although the rationale is not completely clear in the records. Filip later made allegations that he had been assaulted by these members of staff when they removed his phone. This complaint was escalated to the ward manager, however, there is nothing further documented in the record regarding an investigation into this allegation. AWP Trust procedure in this circumstance would be to complete an incident form on the Trust adverse incident recording system. All incident forms are then discussed at a Trust Wide Incident Review meeting within twenty four hours. This would then provide opportunity to identify the incident as an 'Allegations Against Staff' concern and a safeguarding referral should also be submitted to the Local Authority as abuse was alleged. The incident reporting system was checked and there were no incident reports submitted in relation to this incident **(Recommendation 26).**

15.7.3 The GP practice that was involved in this review identified that not all of their staff have had domestic abuse training. Other members of staff within the GP surgery have received a variety of training from different providers. It was felt that a consistent approach to training would be beneficial **(Recommendation 27)**.

15.7.4 The GP Practice also identified that in complex cases a serious case review meeting should be held within the surgery. Such an approach would improve patient outcomes and assist in co-ordinating a multi-agency approach beneficial **(Recommendation 28)**.

15.7.5 As a result of this review the Panel felt that the link between GP's and the DA services in Next Link could be strengthened through the implementation of the IRIS

programme[49]. Such a link would improve the reporting and recording of domestic abuse cases **(Recommendation 29)**.

15.7.6 As a result of the review the University Hospitals Bristol and Weston NHSF Trust IMR writer identified that their Domestic Violence and Abuse Policy required updating **(Recommendation 30)**. They also identified that the Information on the intranet system regarding domestic violence and abuse needed to be updated in relation to Safeguarding Adults and Children **(Recommendation 31)**.

15.7.7 The Education IMR writer identified that the transition arrangements for Filip were not robust in terms of monitoring what he was going to do post sixteen. These arrangements were also felt to be particularly important for those individuals who have identified needs (i.e. drugs and alcohol misuse). Improvements therefore need to be made for those that are currently in the system in terms of their onward progression post sixteen **(Recommendation 32)**.

15.8 **Training**

15.9 The review identified that there was a discrepancy between agencies' perception of the support that was offered to the family and the families actual experience. The Vesta representative on the Panel reiterated how important it was to ensure that staff are culturally aware. Agencies need to undertake a training needs analysis to identify whether additional training in terms of cultural awareness should be delivered to staff, to ensure that they can adequately meet the needs of all communities **(Recommendation 33)**.

15.10 **Vulnerability factor - Employment**

15.10.1 Employment appeared to be an important factor in terms of stability in Filip's life. He appeared to be motivated to secure full time permanent employment to enable him move out of the family home. However in February 2021 he lost his job but later found another position in a factory. At this time the mental health team who were working with Filip referred him for additional support to help him to secure employment through Individual Placement and Support (IPS). IPS is an employment support service integrated within community mental health teams for people who experience severe mental health conditions. The team supported him to develop his curriculum vitae in an attempt to enable him to apply for jobs in retail. The referral to this service demonstrated good practice and acknowledged the external factors which appeared important to Filip. Unfortunately in early April 2021 Filip lost his factory job. It appears that following this there was a deterioration in presentation and an increase in observed tensions between Filip and his parents.

16.0 Conclusions

[49] IRIS is a specialist domestic violence and abuse (DVA) training, support and referral programme for General Practices.

16.1 Piotr found himself in a situation where he was desperate to protect and help his son but was unsure about the help that was available to support him in that process. He and his wife recognised that Filip's misuse of alcohol and cannabis had led to the rapid deterioration in his mental health and despite being a very private individual he had reached out for that help after concluding that the family was unable to cope alone.

16.2 In this case all four adults had claimed that they had been subjected to abuse by family members and although they had reported a number of incidents to the police the true extent of what was happening at home only became evident after the death of Piotr. The strong desire by his family meant that they did not want their son criminalised and simply wanted him to be cared for and treated by Health services.

16.3 The abuse perpetrated by Filip appeared to have started suddenly in his adolescent years. The levels of abuse and the resulting risks to others would increase when he misused illicit drugs or at crisis points in his life such as when he found himself unemployed.

16.4 From the information that is available from agency records it is clear that Filip was the perpetrator of domestic abuse and was controlling and coercive in his relationship with his girlfriend and his parents. His abusive behaviour was undoubtedly driven by the decline in his mental health. He had become paranoid about his father having a relationship with his girlfriend and that his family were going to kill him.

16.5 Filip had been assessed in terms of his mental illness and had been receiving treatment commensurate with his diagnosis. Following his discharge from a secure unit he had been supported in the community by professionals who were actively trying to assist him in improving his mental health and his life skills in terms of his employment.

16.6 In the days leading up to the death of Piotr there were clear signs of deterioration in Filip's behaviour. These signs were recognised by his family but this change in behaviour was not unusual and they continued to support their son in the hope that he would recover from his illness.

16.7 The review identified a number of areas of learning in respect to agency response to the domestic abuse incidents reported by Piotr and his family. There was a failure by all agencies to follow established procedures in relation to risk recognition and the referral of cases to MARAC. Had the case been reviewed by the MARAC then this would have provided all agencies with the ability to share information and they would then have had a holistic picture of the family's circumstances.

16.8 The review also identified that there were a number of areas of learning and improvement in terms of developing pathways to support those with complex needs. These pathways which include access to mental health services, programmes to address abusive behaviour and drugs/alcohol support programmes would assist professionals and family members in developing effective frontline services that supports their needs.

16.9 In this case there were several missed opportunities by professionals to fully engage with Piotr and his family. There was a lack of professional curiosity and an appreciation of the wider safeguarding issues that may have been occurring within the family set up.

16.10 There was a multi-agency response to Filip's discharge from the secure unit but it is unclear from the records held whether all of the risks presented in this case were fully considered or if they were then they were not recorded. Effective recording of risk management processes are vital in terms of the management of individuals with complex needs. Had these risks been fully assessed then an alternative support may have been provided to the family.

16.11 The discharge process from the secure unit was found to be inadequate in terms of the involvement and assessment of the needs of Filip's parents. The review has identified a number of areas for improvement in terms of the management of such cases by Health staff in UHBW and AWP.

16.12 Some of the professionals involved with the family lacked a true understanding of the cultural and language barriers that may exist when dealing with individuals from diverse communities. The review has identified that agencies could work harder to adapt current service provision to meet the needs of diverse groups living and working in the North Somerset community. This includes the increased use of interpreters and availability of literature to support these wider communities. Where agencies did use Polish speaking professionals to engage with the family then this was found to be beneficial in terms of increasing engagement. Knowledge of the unique contexts that involve diverse communities and the barriers that they face have implications for practice in all services. There is a need for all agencies to take proactive steps to make statutory services more accessible.

16.13 There were occasions were the information that was exchanged between agencies was inaccurate and there were identified poor recording practices within both UHBW and AWP. In many instances there was a failure to follow existing policy and procedures.

16.14 The review has identified a number of areas where policy needs to be updated and as an outcome of this case the multi-agency response to domestic abuse will be strengthened.

16.15 Many of the agencies involved have already started to embed the learning into practice. These changes will be monitored by the Partnership and delivered through the Domestic Strategy which was published in January 2022.

17.0 Learning/Recommendations

17.1 The learning opportunities identified in this case are listed below and have been translated into recommendations;

- Learning opportunity

The GP surgery identified that a joint case review meeting should be held with AWP for suitable cases where individuals have complex needs. No recommendation has been made in respect of this point of learning as this practice has now been implemented.

- Learning opportunity (Recommendation 1)

The review highlighted the importance of mental health service pathways being available to frontline staff within the Avon and Somerset Constabulary.

Recommendation 1 – ASC Mental Health Theme Lead, AWP and CAMHS to work to review and deliver improved current pathways into Mental Health Services.

- Learning opportunity (Recommendation 2)

As a result of the review the ASC Procedural guidance the link to the APVA Guidance was found to be inoperable.

Recommendation 2 – ASC to update the DA procedural guidance and training to ensure that all links contained within the document are accessible to frontline staff.

- Learning opportunity (Recommendation 3/4)

Staff working at UHBW/AWP Hospitals failed to think holistically about the wider safeguarding implications within the family. The “Think family” model assists frontline practitioners to develop professionally curiosity and ask relevant questions to mitigate threat, risk and harm.

Recommendation 3 – University Hospitals Bristol and Weston NHSF Trust to review and implement changes to current practice in ED’s to ensure that its being delivered through the lens of the Think Family Model.

Recommendation 4 – University Hospitals Bristol and Weston NHSF Trust safeguarding training programmes to be reviewed to re-enforce the importance of the ‘make every contact count’ rule and the use of the ‘Think Family’ model.

- Learning opportunity (Recommendation 5)

The AWP IMR author identified that they need to audit the validation of records to review whether the issues found in this report are isolated incidents or evidence that further development is required.

Recommendation 5 – AWP Quality Improvement Lead in North Somerset to audit a randomly selected sample of North Somerset Service User records to review whether all entries were validated in the 6 months prior to the audit being conducted.

- Learning opportunity (Recommendation 6)

In this case agencies failed to follow the current system in relation to MARAC referrals and the offer/provision of support.

Recommendation 6 - Police together with North Somerset Partnership to review the MARAC process and implement changes to improve its effectiveness.

- Learning opportunity (Recommendation 7)

AWP identified that they need to check and test staff knowledge of identifying and responding to domestic abuse, including identifying domestic abuse outside the intimate partner dyad.

Recommendation 7 – AWP to conduct a staff survey to check and test staff understanding and confidence in identifying and assessing domestic abuse. Survey to include checking staff knowledge of non-intimate partner domestic abuse and to consider the cultural impact of domestic abuse.

- Learning opportunity (Recommendation 8)

APVA needs to be integrated into the domestic violence framework and strategy in North Somerset to ensure that staff in all agencies recognise such abuse and deal with it appropriately.

Recommendation 8 – North Somerset Partnership to convene a working group of statutory partners to ensure that APVA policies and practice are embedded in frontline practice.

- Learning opportunity (Recommendation 9)

AWP to improve current practice to support staff with assessing, signposting and referring service users to domestic abuse support services including support for individuals where English is not their first language.

Recommendation 9 – AWP and substance misuse services to develop a directory of services to support staff in the assessing, signposting and referring of service users to domestic abuse services. This to include signposting to the DASH risk assessment in other languages.

- Learning opportunity (Recommendation 10)

At present support pathways for those engaged in abusive behaviours are extremely limited in North Somerset.

Recommendation 10 – The 'PREVENT' strand in the North Somerset Domestic Abuse Strategy should include the development of pathways for those who are engaged in abusive behaviour (perpetrators). The support offered to those committing domestic abuse should be also accessible to non-English speaking communities.

- Learning opportunity (Recommendation11)

  There were identified gaps in the communication between the acute hospital and the CIOT (Crisis Intervention and Outreach Team) relating to Filip (who was a child at that time) leaving the premises without assessment or the risks being identified.

  Recommendation 11 – CIOT Manager to liaise with acute hospitals in Bristol around protocols to notify on call Mental Health Manager OOH or CIOT during day time hours.

- Learning opportunity (Recommendation 12/13)

  ED staff working for the University Hospitals Bristol and Weston NHSF Trust failed to follow existing mental health pathways for Filip and didn't complete the Mental Health Matrix. At present a working party has been established to look at the experiences of 16-18yr olds to improve practice. The outcomes of the working party group need to be shared with the Trust Children's Mental Health Operational Group lead to improve current practice.

  Recommendation 12 – University Hospitals Bristol and Weston NHSF Trust to recirculate the Mental Health Matrix pathway relating to 16-18 year olds presenting with mental health issues to the Emergency Departments This will provide staff with a framework for mental health presentations and the details for escalation for out of hour's advice.

  Recommendation 13 – Outcomes of the University Hospitals Bristol and Weston NHSF Trust working party group regarding the experiences of the 16-18 year old groups to be shared with Safeguarding Children lead.

  Learning opportunity (Recommendation 14)

  The use of the Mental Health Matrix risk assessment tool for patients in 16-18 year age group who present to either emergency department within the University Hospitals Bristol and Weston NHSF Trust with Mental health problems needs to be embedded into culture and practice.

  Recommendation 14 – The medical team in UHBW Emergency Department's to conduct an audit of the completion of the Mental Health Matrix 16-18 year old age group.

  Learning opportunity (Recommendation 15)

  When Filip presented in crisis to the hospitals a HEEADSSS assessment should have been conducted to assist in a safeguarding risk assessment. Learning from this review can enhance the importance of this tool.

Recommendation 15 – University Hospitals Bristol and Weston NHSF Trust to conduct HEEADSSS assessment ED's audits in September, October and November 2022 to identify compliance issues.

- Learning opportunity (Recommendation 16)

Mental Capacity Act assessment and best interest decisions should be considered for all people who present to the emergency dept. where there is evidence to suggest an impairment of mind or brain.

Recommendation 16 – University Hospitals Bristol and Weston NHSF Trust to raise awareness of the need for Mental Capacity Act assessments and best interest decisions though sharing the patient story with the ED team.

- Learning opportunity (Recommendation 17)

Staff in the two ED's of the UHBW NHS Trust did not use a Polish speaking service to assist in the risk assessments that were initially carried out in that department. The use of such a service could have overcome barriers to communication.

Recommendation 17 – University Hospitals Bristol and Weston NHSF Trust to promote the use of interpreters in line with current policy to all ED staff.

- Learning opportunity (Recommendation 18)

AWP identified that staff have not had any form of training regarding the completion of care plans. Such training should incorporate the accurate assessment of risk.

Recommendation 18 – AWP to develop training regarding the completion of care plans as part of the Trust Wide Quality Improvement programme.

- Learning opportunity (Recommendation 19)

The review identified that agencies were unfamiliar with the current process for drug and alcohol referrals. These processes need to be reviewed in order for individuals with complex needs to be effectively supported.

Recommendation 19 – Police, AWP and CAMHS to review the current referral pathways in North Somerset for vulnerable groups.

- Learning opportunity (Recommendation 20/21)

The accurate recording of the nationality of domestic abuse victims and perpetrators will assist in delivering services that meet the needs of specific client groups.

Recommendation 20 (National/Local) – All agencies involved in this case to review and amend current recording practices to ensure that nationalities are accurately recorded for all cases.

Recommendation 21 - North Somerset DA services to publish guidance promoting the development of recording practices which ensures that nationalities are accurately recorded for all domestic abuse cases.

- Learning opportunity (Recommendation 22)

The current provision and use of interpreter services in North Somerset needs to be improved. These translators need to be appropriately trained.

Recommendation 22 – North Somerset Partnership to work with Health providers, Domestic Abuse Services, Housing and Adult Social Care to review and implement changes to improve local interpreter services in the County.

- Learning opportunity (Recommendation 23)

The availability of multilingual literature across all agencies relating to domestic abuse services was found to be variable.

Recommendation 23 - North Somerset Partnership to work with Health providers, Domestic abuse Services, Housing and Adult Social Care, Drugs and Alcohol Teams to review and improve local literature (relating to domestic abuse, mental health, therapeutic interventions) for appropriate foreign national groups based on the demographics in the community.

- Learning opportunity (Recommendation 24)

Although the Polish community has a large presence in North Somerset there are no identified support groups in the area. The North Somerset Partnership should review the current support groups that are available in the area for non-English speaking communities to enhance current service provision in the area.

Recommendation 24 - North Somerset Partnership to undertake a review of the current support groups that are available in the area for non-English speaking communities.

- Learning opportunity (Recommendation 25)

In this case Filip presented in crisis at two UHBW hospitals ED and there was limited access to medical records across the two sites. Access to electronic patient records across both sites is essential in order to plan patient care and reduce risks.

Recommendation 25 – The University Hospitals Bristol and Weston NHSF Trust to review and improve current access arrangements to electronic patient records across the two hospital sites.

- Learning opportunity (Recommendation 26)

In this case AWP staff were not aware of and failed to utilise the Allegations Against Staff process.

Recommendation 26 – AWP to develop management of allegations against staff procedure as part of the Safeguarding improvement programme aligned to Safeguarding policies.

- Learning opportunity (Recommendation 27)

The GP surgery involved in this review identified that not all of their staff have received domestic abuse training.

Recommendation 27 – The GP Practice should undertake a training needs analysis for all of its staff in relation to domestic abuse training.

- Learning opportunity (Recommendation 28)

The GP Practice identified that in complex cases such as this a serious case review meeting should be held within the surgery. Such an approach would assist in improving patient outcomes and assist in co-ordinating a multi-agency approach.

Recommendation 28 – The GP Practice to implement a serious case review meeting structure within the Practice.

- Learning opportunity (Recommendation 29)

The review identified that there were opportunities to improve the links between GP services and the specialist domestic abuse services in North Somerset.

Recommendation 29: GP's to develop an IRIS programme of direct referral by primary services to the DA services in Next Link.

- Learning opportunity (Recommendation 30)

University Hospitals Bristol and Weston NHSF Trust identified that their Domestic Violence and Abuse Policy required updating.

Recommendation 30 – University Hospitals Bristol and Weston NHSF Trust to review and amend their domestic abuse policy to reflect changes regarding the inclusion of children aged sixteen.

- Learning opportunity (Recommendation 31)

The IMR writer for University Hospitals Bristol and Weston NHSF Trust found that the Information on the intranet system regarding domestic violence and abuse needed to be updated in relation to Safeguarding Adults and Children.

Recommendation 31– University Hospitals Bristol and Weston NHSF Trust to review and amend all policy and practices to ensure that the information reflects current national guidance and legislation in relation to Safeguarding Adults and Children.

- Learning opportunity (Recommendation 32)

The Education IMR writer identified that the transition arrangements for Filip were not robust.

Recommendation 32 – The school involved in this review to review current school transition arrangements to post-16 education and implement findings to improve safeguarding arrangements for children.

Learning opportunity (Recommendation 33)

The Review identified that there was a discrepancy between agencies' perception of the support that was offered to the family, and the family's actual experience. Improvements in staff awareness of cultural; differences would assist in ensuring that service delivery meets the needs of all groups in the community.

Recommendation 33 - All agencies involved in the review to undertake a training needs analysis to identify gaps in training relating to cultural awareness.

Glossary

AFFDA -	Advocacy After Fatal Domestic Abuse - An independent organisation offering specialist and expert Advocacy and peer support after fatal domestic abuse.
APVA -	Adolescent to Parent Violence and Abuse- A term used to describe abuse and violence that children may inflict on their parents.
ASC -	Avon and Somerset Constabulary- The Police Force covering the North somerset area.
AWP -	Avon and Wiltshire Mental Health Partnership NHS Trust- The service provides healthcare for people with serious mental illness, learning disabilities and autism in inpatient (hospitals) and community based settings.
CAMHS -	Child and Adolescent Mental Health Service – CAMHS is the name for the NHS services that assess and treat young people with emotional, behavioural or mental health difficulties.
CCG -	Clinical Commissioning Group – These are clinically-led statutory NHS bodies responsible for the planning and commissioning of health care services for their local area.
CPVA	Child to parent Violence and Abuse
DAO -	Domestic Abuse Officer – Police Officer with specialist skills and training to support victims of domestic abuse.
DASH -	Domestic Abuse, Stalking and Honour Based Violence – A risk assessment tool used by agencies used to identify risks and inform decision making following a domestic abuse incident.
DH -	Domestic Homicide.
DHR -	Domestic Homicide Review.
ED -	Emergency Department - An emergency department (ED), also known as an accident and emergency department (A&E), emergency room (ER), emergency ward (EW) or casualty department, is a medical treatment facility specializing in emergency medicine, the acute care of patients who present without prior appointment.
EI -	Early Intervention - support given to a family when a problem first emerges.
GP -	General Practitioner.
HO -	Home Office - The Home Office (the Department) is the lead government department for crime, the police, drugs policy, immigration and passports, and counter terrorism.
IMR -	Independent Management Review- a document that is completed by agencies to inform the DHR process.
IST -	Intensive Support Team- Intensive support teams (ISTs) are specialist teams which have been advocated for many years as the best services to help people with ID and challenging behaviour remain within their local communities. The teams may be staffed by one or more professions (e.g., psychology, nursing, psychiatry).
LSU -	Lighthouse Safeguarding Unit - Lighthouse is a team of staff from the police and victim support organisations, working together to guide, advise and support victims and witnesses.
MARAC -	Multi Agency risk assessment conference - A Multi Agency Risk Assessment Conference (or MARAC) is a meeting that is held to discuss the most high risk cases of domestic abuse and sexual violence, to share information and to safety plan to safeguard a victim.

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MCA -	Mental Capacity Act - The Mental Capacity Act 2005 (MCA) provides a statutory framework for people who lack capacity to make decisions for themselves, or who have capacity and want to make preparations for a time when they may lack capacity in the future.
MH- TAC -	Mental Health Tactical Advisor- Police Officer trained to provide help and support to front line staff about mental health.
NHSE -	National Health Service England.
NHSF -	National Health Service Foundation - NHS foundation trusts were created to devolve decision making from central government to local organisations and communities. They provide and develop healthcare according to core NHS principles
NSC -	North Somerset Council – The Local Authority for the area in which this event happened.
RE -	Routine enquiry - Routine enquiry involves asking all women at assessment about abuse regardless of whether there are any indicators or suspicions of abuse.
UHBW -	University Hospitals Bristol and Western NHS Trust.

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