Executive Summary

North Somerset Safer Communities

DHR 5

Year of Death 2021.

Author: Paul Northcott

Date the review report was completed: July 2022

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1.0 Review Process

1.1 This summary outlines the process undertaken by the North Somerset Safer Communities Partnership domestic homicide review panel in reviewing the death of Piotr who was resident in their area.

1.2 The following pseudonyms have been used in this review to protect the identities of the relevant people who were involved;

- Piotr – Deceased male. Piotr's ethnicity was white European and he was aged thirty eight at the time of his death.
- Filip – Piotr's son. Filip's ethnicity is white European and he was eighteen years old at the time that his father died.
- Piotr's wife
- Filip's girlfriend.

1.3 Criminal proceedings were completed in December 2021 and Filip was found guilty of manslaughter. Filip was sentenced and detained under a Hospital and Restriction Order[1]. Filip has since been diagnosed with paranoid schizophrenia.

1.4 The decision to commission a review was taken by the Chair of the North Somerset Safer Communities Partnership on the 5th May 2021. All agencies that potentially had contact with Piotr, his son Filip and their family, prior to the point of death were contacted and asked to conform whether they had involvement with them.

1.5 Nine of the twenty-two agencies contacted confirmed that they had involvement with Piotr, his son Filip and the other family members.

2.0 Contributors to the Review

2.1 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

[1] Mental Health Act 1983

- 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.
- Next Link - Specialist domestic abuse advice and information.

2.2 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.

2.3 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.

2.4 All of the IMR writers were independent. None of the writers 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.

3.0 The Review Panel Members

3.1 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 – Former Head of Adult Safeguarding, BNSSG CCG
- Jacqueline Keane –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

3.2 The Panel met formally on five occasions. All of the Panel members were independent. None of the members knew the individuals concerned or had direct involvement in the case.

4.0 Author of the Overview Report.

4.1 The Cornwall Community Safety Partnership appointed Paul Northcott as Independent Chair and author of the overview report in November 2021.

4.2 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.

4.3 Paul retired from the police service in February 2017. Paul has not worked for Cornwall Safer Communities Partnership, nor any of the agencies involved in this review in the period specified in the review.

4.4 Paul has been trained as a DHR Chair, is a member of the DHR network and has attended AAFDA[2] webinars.

5.0 Terms of Reference

5.1 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;

[2] Advocacy after fatal domestic Abuse.

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

5.2 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.

5.3 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.

5.4 The methods for conducting DHR's are prescribed by the Home Office guidelines[3]. 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'*.

6.0 Summary

6.1 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. All three family members lived in a house in North Somerset which they owned.

6.2 Piotr's wife stated that she and her husband noticed a significant change in Filip's behaviour in the September of 2020 in that he could become aggressive.

6.3 Filip's girlfriend came to England in Oct 2020. At that time she was aged seventeen. 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. When Filip's girlfriend first arrived in England, she stayed at the family's home address.

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

6.4 From April 2020 onwards Filip's mental health deteriorated. His mother stated that COVID restrictions 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.

6.5 Filip had become verbally and physically aggressive to both of his parents and his girlfriend. On one occasion (October 2020) Filip had threatened his girlfriend and his father with a knife (this had not been witnessed by Piotr's wife). He had also held his girlfriend by the throat.

6.6 From October 2020 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.

6.7 In November 2020 Filip was admitted to hospital, and detained under the Mental Health Act 1983. On being discharged, in December 2020, 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.

6.8 In the seven to ten days prior to the death of Piotr, in April 2021, his parents would lock Filip 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.

6.9 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.

6.10 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. Officers attended and forced entry into the property and Piotr was found in an upstairs bedroom. He had multiple stab wounds to his body. Filip was arrested for attempted murder and taken into custody. Piotr did not regain consciousness and Filip was later arrested for murder.

6.11 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.

6.12 A forensic post-mortem of Piotr's body was carried out which concluded that he had died from stab wounds to his chest.

7.0 Key Issues Arising from the Review

7.1 **Domestic Abuse**

7.1.1 There was no information to suggest that Filip had been violent or abusive (which is commonly termed as adolescent to parent violence and abuse (APVA)) [4] to either of his parents whilst he was growing up.

7.1.2 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.

7.1.3 The abuse perpetrated by Filip appeared to have started suddenly and could be 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. From the information that is available in agency records it is clear that Filip was abusive, controlling and coercive[5] in his relationship with his girlfriend and parents.

7.1.4 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 and referrals made to appropriate agencies. Despite the Police making a referral to CAMHS on that occasion, 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. The current referral process for those with complex needs therefore needs to be reviewed (**Recommendation: 1**).

7.1.5 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 and was threatening his girlfriend, and he was being increasingly aggressive to his mother.

[4] Condry and Miles (2012; 2015), Coogan, D (2018).
[5] Controlling or Coercive Behaviour in Intimate or Family Relationship Statutory Guidance Framework; Dec 2015; Home Office

7.1.6 On the 25th October 2020 Police 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. This was never followed up by the Police.

7.1.7 On the 27th October 2020 Police attended the home address following a report that Filip had been assaulted by his mother. On 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 and his wife both claimed that their son had become aggressive towards her. At that time neither his mother, nor his girlfriend wanted to pursue any further complaint. On this occasion the officers completed a DASH risk assessment for all of the family members. The risk assessment at that time was graded as 'High'.

7.1.8 The Police Force has adopted the College of Policing Authorised Professional Practice guidance regarding Adolescent to Parent Violence and Abuse (APVA)[6] 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.

7.1.9 On reflection the Police IMR writer identified that additional action could have been considered by the officers attending the address and additional referrals made including one to MARAC. There were also discrepancies in the information exchanged between EI and the Police in relation to the risks posed by Filip.

7.1.10 The Police did take positive action in November 2020 when Piotr contacted the them in relation to Filip assaulting his girlfriend. Despite the lack of a compliant the Police arrested Filip for the assault. A victimless prosecution was considered but on review the decision was made that there was insufficient evidence to progress the case.

7.1.11 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 claimed that the information that they had received was confusing and that they were made to feel that most people would not call the Police for such matters. Piotr's wife also claimed that they had also not been informed of their options in terms

[6] 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.

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

7.1.12 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[7] 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. There was also a lack of professional curiosity in relation to the reported volatile and aggressive actions towards his girlfriend.

7.1.13 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.

7.1.14 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 occurring. 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[8] by Health services must be promoted within GP and A&E services in North Somerset (**Recommendation 3/4**).

7.1.15 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. There was however some confusion about whether the forms had been fully completed and a referral made. 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.

[7] 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.

[8] 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'.

7.1.16 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[9] 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).**

7.1.17 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. Both Piotr, his wife and his girlfriend could have also been signposted to other services suitable to meet their needs as Polish internationals.

7.1.18 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, There were other missed opportunities by AWP Mental Health staff to complete a DASH assessment with Piotr and his wife. 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).**

7.1.19 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[10] provision. 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)**.

7.1.20 Since April 2021 there has been AWP Trust wide domestic abuse training programme offered to staff. AWP have 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)**.

[9] RiO - Information about patients is inputted and stored on an electronic patient record system called RiO.

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

7.1.21 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. At present pathways to help victims and individuals engaging in abusive behaviour 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[11] of non-English speaking groups. and that to be effective they may need to be delivered in their native language **(Recommendation 10)**.

7.2 Mental Health/Safeguarding Practice

7.2.1 Mental health is a significant issue in homicides and is recorded as the second most common health-related theme in the DHR reports.[12]. In Filip's case the use of cannabis and alcohol together with the effects of him being isolated through COVID had led to a sudden and unexpected deterioration in his mental health.

7.2.2 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.

7.2.3 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.

7.2.4 At that time 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)**.

7.2.5 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. In Filip's case there were no records that the out of hours teams (Child and Adult Mental

[11] 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)

[12] Sharp-Jeffs and Kelly (2016)

Health Service (CAMHS)) were contacted. 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)**.

7.2.6 There was no evidence that the UHBW acute NHS Trust, Mental Health Matrix (which includes safeguarding considerations) was completed in either of the 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[13]. The Matrix could also have resulted in the consideration of a Section 136[14] 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)**.

7.2.7 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 completion of the HEEADSSS may have promoted staff to make a safeguarding referral. **(Recommendation 15)**.

7.2.8 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[15] (MCA) Assessments to be completed on the two occasions that Filip discharged himself. In Filip's case it would appear that there was an assumption that he had capacity to make decisions in terms of his treatment. 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)**.

7.2.9 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 **(Recommendation 17)**.

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[13] 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.

[14] 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'.

[15] Mental Capacity Act 2005

7.2.10 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. In this case the family were severely disadvantaged due to language barriers and the inability of staff to access interpreters.

7.2.11 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 Mental Health team supporting Filip felt that the Early Intervention Psychosis team was effectively monitoring his case and appropriately treating him.

7.2.12 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 felt that they had no choice but to care for their son following his discharge. The discharge procedure from the secure unit would appear to have been poorly co-ordinated with no full consultation with the family. This is poor practice.

7.2.13 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. Whilst there is clear guidance in place, 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)**.

7.2.14 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.

7.3 **The Polish Community**

7.3.1 The Polish Community is known to be the largest 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)**.

7.3.2 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[16]. Such mistrust can often prevent individuals from reporting issues such as domestic abuse to the authorities and prevent them from seeking help[17]. 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.

7.3.3 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.

7.3.4 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. 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[18] **(Recommendation 22)**.

7.3.5 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. 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)**.

[16] Notes from Poland (2020)
[17] Notes from Poland (2020)
[18] Farmer E, Callen S (2012); Barrow-Grint (2016)

7.3.6 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)**.

7,4 **Information governance issues**

7.4.1 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". Connecting the record systems across the two hospital sites would improve accessibility for staff and the ability for them to accurately assess risk **(Recommendation 25)**.

7.5 **Operational Practice/Policy**

7.5.1 As part of his AWP 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, his phone was removed from him. Filip later made allegations of assault against staff. The incident reporting system was checked and there were no incident reports submitted in relation to this incident which indicated a failure to follow policy **(Recommendation 26).**

7.5.2 The GP practice that was involved in this review identified that not all of their staff have had domestic abuse training. It was felt that a consistent approach to training would be beneficial **(Recommendation 27)**.

7.5.3 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)**.

7.5.4 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[19]. Such a link would improve the reporting and recording of domestic abuse cases **(Recommendation 29)**.

7.5.5 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

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

intranet system regarding domestic violence and abuse needed to be updated in relation to Safeguarding Adults and Children **(Recommendation 31)**.

7.5.6 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. Improvements therefore need to be made for those that are currently in the system in terms of their onward progression post sixteen **(Recommendation 32)**.

7.6 **Training**

7.6.1 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. 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)**.

8.0 Conclusions

8.1 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.

8.2 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.

8.3 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.

8.4 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.

8.5 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.

8.6 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.

8.7 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.

8.8 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.

8.9 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.

8.10 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.

8.11 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.

8.12 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.

8.13 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. There was a failure to follow existing policy and procedures that existed at that time.

8.14 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.

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

9.0 Learning and Recommendations

9.1 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.
