



DOMESTIC HOMICIDE REVIEW

BASILDON COMMUNITY SAFETY PARTNERSHIP

Case of Sarah

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1. DHR BASILDON COMMUNITY SAFETY PARTNERSHIP, Sarah

Overview Report

Introduction

1.1 Outline of the incident

- 1.1.1 On the day of the homicide, a member of the public called police as he had heard a female shouting and seen a male making stabbing motions on top of her. Officers attended and found Brendan covered in blood, and discovered Sarah within some bushes to which Brendan had moved her. Sarah died later in hospital as a result of blood and fluid loss caused by over 80 stab wounds.
- 1.1.2 Brendan was charged with Sarah's murder, and convicted after trial. He was sentenced to life imprisonment with a minimum term of 23 years.
- 1.1.3 Sarah was aged 21 at the time of her death. She lived at her work place with Brendan, who she had been in a relationship with for around six months. She loved her work with animals, and had plans for travelling abroad in the future to pursue this further. It is believed, from information provided by her mother to the Review, that Sarah wanted to end the relationship, and that this may have been a precursor to the homicide. Sarah's mother described her as "*a beautiful young girl that died too early*".
- 1.1.4 The DHR Panel expresses its sympathy to the family and friends of Sarah for their loss.

1.2 Domestic Homicide Reviews

- 1.2.1 Domestic Homicide Reviews (DHRs) were established under *Section 9(3), Domestic Violence, Crime and Victims Act 2004*.
- 1.2.2 The Basildon Community Safety Partnership, in accordance with the Revised Statutory Guidance for Domestic Homicide Reviews (March 2013), commissioned this Domestic Homicide Review.
- 1.2.3 Essex Police notified Basildon Community Safety Partnership on 8 July 2015 that the case should be considered as a DHR. The Basildon Community Safety Partnership made a decision to conduct a DHR, and having agreed to undertake a review, notified the Home Office of the decision on 24 July 2015 (within Home Office Statutory Guidance timescales).

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- 1.2.4 The purpose of these reviews is to:
- (a) Establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims.
 - (b) Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result.
 - (c) Apply those lessons to service responses including changes to policies and procedures as appropriate.
 - (d) Prevent domestic homicide and improve service responses for all domestic violence and abuse victims and their children through improved intra and inter-agency working.
- 1.2.5 This review process does not take the place of the criminal or coroners courts nor does it take the form of a disciplinary process.
- 1.2.6 The first meeting of the DHR Panel was held on 5 October 2015, with subsequent meetings on 19 January 2016, 6 April 2016 and 25 May 2016. The report was handed to the Basildon Community Safety Partnership in October 2016.
- 1.2.7 Home Office guidance states that the DHR should be completed within six months of the initial decision to establish one. Delays occurred in this review due to waiting for information to be submitted from some agencies, whose involvement with the case was only established once the Review was underway. In addition, Sarah's mother expressed her wish to contribute to the review at a very late stage, and hence the completion of the Review was delayed to ensure she had adequate time to do this, without being rushed.

1.3 Terms of Reference

- 1.3.1 The full terms of reference are included at Appendix 1. This Review aims to identify the learning from Sarah's and Brendan's case, and for action to be taken in response to that learning; with a view to preventing homicide and ensuring that individuals and families are better supported.
- 1.3.2 The DHR Panel comprised agencies from Basildon, as Sarah and Brendan were living in that area at the time of the homicide. The Community Safety Partnership conducted a scoping exercise as soon as the DHR had been established, and prior to the first DHR Panel meeting. Through this process, and through information provided during the Review, it was established that Brendan had contact with agencies in other parts of the country and therefore agencies were contacted for information and involved remotely in the Review.

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- 1.3.3 At the first meeting, the DHR Panel shared brief information about agency contact Sarah and Brendan (in addition to the information gathered through the scoping exercise) and as a result, established that the most useful time period to be reviewed would be from 1 January 2006 to the date of the homicide. It was felt that this would capture the significant contacts with agencies. Agencies were asked to summarise any relevant contact they had had with Sarah or Brendan prior to that date.
- 1.3.4 At the first DHR Panel meeting the Chair and Panel discussed any issues that would be particularly pertinent to this Review. It was agreed that the very young age of both Sarah and Brendan were issues to be addressed through the Review. In addition, given the absence of any contact by agencies with Sarah, the DHR Panel agreed that it would be essential to address the provision of information to members of the public – including friends and family of potential victims/survivors of domestic abuse – about the issue of domestic abuse and access to services. The local domestic abuse specialist service, Changing Pathways (formerly Basildon Women’s Aid) was therefore asked to be part of the Review.

1.4 Independence

- 1.4.1 The Chair of the Review was Althea Cribb, an associate DHR Chair with Standing Together Against Domestic Violence. Althea has received Domestic Homicide Review Chair’s training from Standing Together. Althea has over nine years’ experience working in the domestic violence and abuse sector, currently as a consultant supporting local strategic partnerships on their strategy and response to domestic violence and abuse. Althea has no connection with the Basildon Community Safety Partnership or any of the agencies involved in this case.
- 1.4.2 Standing Together Against Domestic Violence is a UK charity bringing communities together to end domestic abuse. We aim to see every area in the UK adopt the Coordinated Community Response, in order to: keep survivors and their families safe, hold abusers to account and change damaging behaviours, and prevent and ultimately end domestic abuse. Standing Together has been involved in the Domestic Homicide Review process from its inception, chairing over 50 reviews.

1.5 Parallel Reviews

- 1.5.1 There were no reviews conducted contemporaneously that impacted upon this review.

1.6 Methodology

- 1.6.1 The approach adopted was to seek Individual Management Reviews (IMRs) for all agencies that had contact with Sarah and/or Brendan. Whether they had

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contact was established during the scoping conducted prior to the first meeting, through information provided at that meeting and through letters and telephone calls to those not in attendance, in addition to information provided by other agencies as the Review progressed.

- 1.6.2 It was also considered helpful to involve those agencies that could have had a bearing on the circumstances of this case, even if they had not been previously aware of the individuals involved. In particular, Changing Pathways were invited to be part of the DHR Panel, to provide information about what services Sarah, or someone who knew her, could have accessed (see also 2.3.4).
- 1.6.3 All agencies operating in Basildon reviewed their files and notified the DHR Panel that they had no involvement with Sarah or Brendan and therefore had no information for an IMR, with the exceptions of Sarah's General Practice and North East London NHS Foundation Trust (community health services).
- 1.6.4 Many agencies' involvement with Sarah or Brendan was minimal and therefore, with the DHR Panel's agreement, IMRs were not always completed; the information and analysis was provided in letters.
- 1.6.5 Chronologies of each agency's contacts with the victim and/or perpetrator over the Terms of Reference time period were provided.
- 1.6.6 IMRs or letters were received from:
 - (a) Avon and Wiltshire Mental Health Partnership NHS Trust
 - (b) Durham Constabulary
 - (c) New College Swindon
 - (d) NHS England on behalf of the General Practices for Sarah and Brendan:
 - (i) Ashbourne Medical Centre (Sarah)
 - (ii) Fryerns Medical Centre, Essex (Sarah)
 - (iii) Hawthorn Medical Centre, Wiltshire (Brendan)
 - (iv) Elmtree Surgery, Wiltshire (Brendan)
 - (v) Meadowside Family Health Centre, Solihull (Brendan)
 - (vi) White Horse Medical Practice, Oxfordshire (Brendan)
 - (e) North East London NHS Foundation Trust
 - (f) Oxford Health NHS Foundation Trust: Child and Adolescent Mental Health Services (CAMHS)
 - (g) Tees, Esk and Wear Valleys NHS Foundation Trust

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- (h) Thames Valley Police
 - (i) West Midlands Police
 - (j) Wiltshire Police
- 1.6.7 The letters and IMRs received were of high quality and enabled the DHR Panel to analyse the contact with Sarah and/or Brendan, and to produce the learning for this Review. Where necessary further questions were sent to agencies and responses were received. The IMRs and letters made agency recommendations, and the Review saw evidence that action had already been taken on these.
- 1.6.8 Agency members not directly involved with the victim, perpetrator or any family members, undertook the IMRs or letters.
- 1.6.9 The DHR Panel members and Chair were:
- (a) Althea Cribb, Chair (Associate, Standing Together Against Domestic Violence)
 - (b) DI Caroline Venables, Essex Police
 - (c) Jessica Barclay-Lambert, Changing Pathways (formerly Basildon Women's Aid)
 - (d) Paula Mason, Basildon Borough Council
 - (e) Sarah Robinson, NHS England
 - (f) Stephen Mayo, Basildon and Brentwood Clinical Commissioning Group
- 1.6.10 DHR Panel representation was at the appropriate level and members demonstrated expert knowledge of local services and domestic abuse. On reviewing the Overview Report, Sarah's mother asked many questions about mental health services, and therefore the Head of Independent Investigations (including mental health) at NHS England (Midlands and Eastern Region) was consulted to provide expertise around the mental health and general practice response in this case.
- 1.6.11 As many of the agencies involved are based away from Essex, or had minimal involvement, they did not attend DHR Panel meetings but were involved via telephone and email in the analysis of the information provided and the final Overview Report. These were:
- (a) Arthur Turnbull, Tees, Esk and Wear Valleys NHS Foundation Trust
 - (b) Chelle Farnan, North East London NHS Foundation Trust

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- (c) Debbie Smith, Avon and Wiltshire Mental Health Partnership NHS Trust (Acute Liaison Team)
 - (d) Duncan Webster, New College Swindon
 - (e) Felicity Parker, Thames Valley Police
 - (f) Jennifer Holton, Wiltshire Police
 - (g) John Cullwick, West Midlands Police
 - (h) Lin Williams, Swindon Borough Council Domestic Abuse Reduction Strategic Lead
 - (i) Luke Pardoe, Avon and Wiltshire Mental Health Partnership NHS Trust (Primary Care Liaison Service)
 - (j) Mandy Round, Oxford Health NHS Foundation Trust: Child and Adolescent Mental Health Services (CAMHS)
 - (k) Paul Goundry, Durham Constabulary
- 1.6.12 The Chair of the Review wishes to thank everyone who contributed their time, patience and cooperation to this review.

1.7 Contact with the family and friends

- 1.7.1 The DHR Panel sought to contact all those who had been engaged with Essex Police during the investigation and trial. This was because Essex Police had no means of contacting other members of Sarah's and Brendan's family, and no other means of doing this were established during the Review.
- 1.7.2 Letters were hand delivered to the family (mother and sister) of Sarah by the Essex Police Family Liaison Officer who was chosen as she was working closely with the family throughout the trial and had developed a trusting relationship with them. The Family Liaison Officer spoke with the family when the letters were delivered, and again at the end of the trial. The family were firm in their response that they did not want to participate in the Review at that time.
- 1.7.3 The Family Liaison Officer also delivered a letter to Sarah's employer, and the independent Chair wrote to them directly once the trial had been completed. No response was received.
- 1.7.4 The appropriate Home Office leaflets were provided each time, along with information about support services including AAFDA (Advocacy After Fatal Domestic Abuse) and Victim Support.
- 1.7.5 As the review progressed, the DHR Panel discussed contacting Sarah's family again, to find out whether, now some time had passed, she felt able to be part of

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the Review. A further letter was written and sent from the Chair to Sarah's mother. This was also sent to the Victim Support Homicide Service, who had been supporting Sarah's mother; following this Sarah's mother gave permission for the independent Chair to contact her. This was done, and the Chair met with Sarah's mother face to face in July 2016.

- 1.7.6 The Chair met with Sarah's mother again for her to review the Overview Report. Her comments and questions led to changes in the Overview Report. At this point Sarah's mother accepted a referral to AAFDA, and the Chair put her in touch with them. A further conversation was had with Sarah's mother to talk through the changes to the Report as a result of her feedback.
- 1.7.7 The DHR Panel discussed contacting Brendan's mother to invite her to be part of the Review. As she had not been involved in the trial or criminal investigation, no contact details could be found for her.
- 1.7.8 The independent Chair also wrote to Brendan in the prison in which he is held, and he indicated that he would be willing to be interviewed. This interview took place in February 2016, and the information gathered has been incorporated into this report.
- 1.7.9 To protect the anonymity of Sarah and Brendan, and their families and friends, pseudonyms were selected for this report. These were approved by Sarah's mother prior to publication.

2. The Facts

2.1 Outline / The death of Sarah

- 2.1.1 On the day of the homicide, a member of the public called Police as he had heard a female shouting and seen a male making stabbing motions on top of her. This was outside Sarah's place of work, where she also lived. Officers attended and found Brendan covered in blood, and discovered Sarah within some bushes to which Brendan had moved her. Sarah died later in hospital as a result of blood and fluid loss caused by over 80 stab wounds.
- 2.1.2 Brendan was charged with Sarah's murder, and convicted after trial. He was sentenced to life imprisonment with a minimum term of 23 years.
- 2.1.3 Sarah had been friends with Brendan for some time having met through mutual friends and maintained contact via phone and social media (while living in different parts of the country). Brendan moved to Essex at the end of 2014 and stayed with Sarah: she had wanted to support him after he had been made homeless. Their intimate relationship started shortly after this. The police investigation suggested that Sarah was aware that if the relationship ended Brendan would have to move out and may become homeless.
- 2.1.4 Sarah's mother, who had spoken with Sarah two days before the homicide, also stated that Sarah had wanted to end the relationship. At that time Sarah's mother had no indication from Sarah that her life was in danger.

2.2 Information relating to Sarah

- 2.2.1 Sarah was aged 21 at the time of her death. She was British (white). She lived at her place of work. She had previously lived with her father in another county, returning to Essex where her mother lives after she had turned 18 and pursuing her dream of working with animals. More information about Sarah, provided to the Review by her mother, is provided in section 3.5 below.

2.3 General Practices (GP)

- 2.3.1 In September 2009 Sarah spoke with Ashbourne Medical Centre (GP) reporting *"Mood swings – few months feeling unhappy, never been particularly happy, has fallen out with one of friends – mainly over some relationships, feels used by friends, has had episodes of binge drinking at parties – has decided to avoid situations where she might drink. Feels she has become what she didn't want to be. OK at school, lives with step-mother and step-sister, father there at weekends only – moved up from London last year to be with Dad – but feels doesn't see him much now. Has issues from childhood – and has seen Safe Speak counsellor at*

[school]. Generally feels fine until things go wrong – tends to be after drinking, no suicidal thoughts”.

- 2.3.2 The GP talked to Sarah about ways to improve her mood, such as getting back into a sport she had enjoyed, trying to spend more time with her father, and speaking with the counsellor again via her school. A note was made for a review in two weeks; there were no further appointments recorded. Two letters were received from Safe Speak, notifying the GP that Sarah was receiving counselling (October 2009) and that Sarah had finished counselling (May 2010)¹.
- 2.3.3 The next record was in February 2012 when Sarah attended the GP and disclosed *“Depressive episode significant symptoms of low mood, feels low self esteem, loneliness and isolation, poor sleep and appetite, has some self harm thoughts, but no serious intent, has previously done some cutting self harm. Mother ... being supportive, [difficult relationship with] father [and] stepmother ... No plans for future – just to get away. No social support or regular relaxation. ... Hopeless outlook.”*
- 2.3.4 The GP recorded advice to Sarah to spend more time with her mother. An anti-depressant was prescribed and the GP referred Sarah to community mental health service (called Pathfinder). A follow up appointment one week later recorded that Sarah was still awaiting the Pathfinder Service assessment and was *“feeling calmer and more motivated ... perhaps listening has helped”*.
- 2.3.5 In March 2012 the GP recorded receipt of copies of two letters sent to Sarah for appointments with the Pathfinder service. In between these two letters being recorded, Sarah attended her GP. A repeat prescription was given for the anti-depressant. Sarah was recorded as being *“much calmer and forward thinking, mood stabilised and appears normal”*. An appointment with the Pathfinder service was referenced, and an *“additional letter”* Sarah had received from Pathfinder about booking an appointment. The GP recorded *“no idea what it related to will enquire and let [Sarah] know.”* A plan was recorded to see Sarah again in six to eight weeks. No further appointments were recorded in relation to Sarah’s mental health.
- 2.3.6 In April and May 2012 the GP recorded notifications from the Pathfinder service that Sarah had not attended either of the two appointments that had been offered to her in the two letters recorded previously. June 2014 Sarah attended her General Practice in Essex with regard to contraception. She was advised to see the community provider, North East London NHS Foundation Trust (see 3.4).

¹ Contact was attempted with Safe Speak but was unsuccessful.

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2.3.7 In January 2015 Sarah spoke on the telephone with her General Practice, reporting a sore throat and earache. She was given a prescription. Sarah was then seen in person a week later; she had not collected prescription, was physically checked and given a new prescription. This was Sarah's last contact with her GP.

2.4 North East London NHS Foundation Trust (NELFT)

2.4.1 Sarah registered with NELFT Sexual Reproductive Health Service on 10 April 2014. On 17 April an appointment was booked for her regarding contraception. This appointment took place on 3 June 2014, following which Sarah was discharged from the service.

2.5 Information from the Family of Sarah

2.5.1 Sarah's mother was interviewed by the independent Chair of the Review. The Chair produced a report from this interview, which Sarah's mother agreed, and is included here.

2.5.2 The independent Chair explained the DHR aims and process and answered all questions Sarah's mother had about them.

About Sarah

2.5.3 Sarah was *"a beautiful young girl that died too early. She was a sweet loving child. She wouldn't harm anybody."*

2.5.4 Sarah *"didn't have many friends, but that's the way she liked it"*; she had *"always been quiet"*.

2.5.5 Sarah had always loved animals, from a very young age.

2.5.6 As a teenager, Sarah *"loved home life, she hated school"* and after starting secondary school, decided she wanted to live with her father, in another part of the country. Hard as it was for Sarah's mother, she agreed, as it was what Sarah wanted.

2.5.7 From that point on she *"loved school"*, but struggled at home, although Sarah's mother was not clear what was happening.

2.5.8 It was at that time that she found out that Sarah was self-harming. Sarah's father had noticed *"scratches on her arm"* but Sarah had explained these as *"the rabbit had scratched her"*.

2.5.9 Sarah came to Essex and did some work experience at a pet store, and after returning to her father's, asked Sarah's mother if she could come back and live with her, which Sarah's mother agreed.

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- 2.5.10 Sarah moved back and signed on for benefits, but “*she said ‘I don’t like that, I need to get something to do.’*” The Job Centre helped Sarah get onto a course about working with animals, and part of that was for her to get a placement, which she did. They then offered her a permanent job, and she worked there until she died. Sarah was “*over the moon*” about the job.
- 2.5.11 There was a flat at her place of work, and the organisation offered for Sarah to live there, which she was keen to do, as she wanted “*her own little bit of independence*”.
- 2.5.12 Sarah’s mother was worried about her “*because she’s so tiny, I worry. I said to her I know you’re an adult, I know you can look after yourself, but anyone could pick you up and walk off with you. She said ‘I can handle myself’ and I think she just wanted to be independent.*”

About Sarah’s relationship with Brendan

- 2.5.13 At school (while Sarah was living with her father) she was friends with a girl who was in a relationship with Brendan. When that girl and Brendan split up, Sarah and he remained friends, staying in contact through Facebook.
- 2.5.14 About Brendan moving to Essex, Sarah’s mother said “*I get a phone call. ‘Mum, one of my friends, do you remember me talking about Brendan?’, [I said] yeah, ‘well he’s been kicked out, the landlord has kicked him out for no reason’ or something so I said oh right, [and she said] ‘can we go and pick him up? Tomorrow? He’s sofa surfing tonight, but he’s got nowhere to go’ [I asked] are you sure you want to do this? [And she said] ‘yes mum, I can’t see him out on the streets.’ I can’t even remember where I went but it was a good two-hour drive. ... And as far as I knew, they were just friends. But by the December, I think I found out November/December, that they had now become an item. So I thought, ok, it’s fine, to me he seemed quiet, they play-fighted and stuff like that, and they seemed alright, you know.*”
- 2.5.15 Sarah’s mother said that Sarah complained that Brendan wasn’t working, wasn’t doing anything at home, and that she had to pay for everything. This may have included an expensive computer.
- 2.5.16 At one point Sarah told her that Brendan had told her not to wear certain clothes, and it was only later after the homicide that Sarah’s mother thought back to this and realised what it could have meant: “*she said something which just didn’t dawn on me, but she said, ‘oh he’s pissing me off’ and I said why, and she said ‘you know these vest tops I normally wear round the yard – I’m not allowed to wear them anymore, because they reveal too much’. I said it’s probably just a man thing, you know what men are like, another male comes into the yard, a bit young, some men don’t like it, they’d rather you had a short sleeved t-shirt on. A little top – you*

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- can't see anything. So she started wearing long sleeved and I was like, no, [and she said] 'oh it's just that I feel a bit cold'. [I] didn't really think. To me it was a bit new I suppose, not thinking on the outskirts of it all."*
- 2.5.17 Sarah's mother said *"from what I can make out now, I didn't realise her and Brendan were going through that rocky a patch, because she's, you don't talk about things like that, but then she's very much like her dad, they don't talk about things, you just get the moan, 'oh, he's sitting at home all day, playing games, he doesn't cook, he don't clean'. She said 'mum I left him instructions how to cook pasta; and I ended up doing it myself, because he couldn't follow the instructions'."*
- 2.5.18 Two days before she died, Sarah's mother had helped Sarah to buy a new fan for Brendan. It was not the one he wanted and Sarah had said, *"he's going to flip his lid"* about that. After this, Sarah had talked to her mother about ending the relationship: *"she said 'I've had enough mum, I don't think I can take much more'. And I said you've got to do what you think is right for you. I can't tell you what to do, I said because, like, if I said to you, tell him to go now, and in two weeks time you're back together, you're going to blame me. It is your sole decision. I almost said to her, why don't you come down to [stay with me] for the weekend, because it was her weekend off, but I didn't. So. You can imagine how guilty I feel every day."*
- 2.5.19 Sarah's mother was angry about the fact that Brendan was known to have mental health issues, and had attempted / threatened suicide a number of times, but that no-one in Essex, particularly Sarah, knew about this. She asked whether there was a way that this information could have been known. This has been addressed in the Review (see 5.2.3).
- 2.5.20 The independent Chair asked Sarah's mother about Brendan's behaviour towards Sarah (trying to control what she wore, for example) and whether she or Sarah saw it as 'abuse'. Sarah's mother answered, *"that's all I really knew. I mean he hasn't got a job, and she's having to pay for his keep, his food, his travel. So I thought, if that's what you want to do, he's your boyfriend at the end of the day, then, we all do it, at times. ... He probably was then trying to control her but I think she was a little bit too independent. As in, 'no – there's certain things I will do but not...' that sort of thing."* Brendan had *"seemed a nice guy"* to her and other family members.
- 2.5.21 The independent Chair asked how Sarah's mother thought Sarah saw the relationship. Sarah's mother answered: *"She never ... you don't tell mum things do you. I think she'd, like, [the] money side of it was another thing, because she wanted to save up, she wanted to go to Australia, she also wanted to go to I think it's Arizona, to work with animals. I think she wanted to emigrate at some stage – animals are her life. And she said 'I can't do it, because I'm spending all my money*

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on rent, food', if he needs clothes I suppose she's bought him clothes. So yeah. I didn't realise their relationship was that bad, because I would have stepped in, I would have said right, you [Brendan], out, now. You can't do this to my daughter. And I would have taken two weeks off [work] and I would have gone and stayed with her, because if he'd have tried to come back..."

- 2.5.22 *"She spoke to her sister. But obviously you know what girls are like, 'please don't tell mum!'. You know. I don't think [her sister] really saw, as she's never really, I don't think she would really understand in a way, the domestic side of it. But yeah she feels really bad because they were on the phone they were talking about going to see a film [just before the homicide]. So, it's hard. She was such a quiet, private person. It's hard to get anything out of her at times. 'It's alright mum, I'm alright, don't worry'."*

Learning for the Review to take on

- 2.5.23 Sarah's mother talked about the need for information to be available in schools, to teach young girls and boys about what behaviours to look out for. *"Because for some of them, that's where they start isn't it, boyfriends, girlfriends. Make them, you know, have a big talk in school, have pamphlets. People say 'just get out, get out now' that's the last thing you say to anybody. But people don't know this. Wait until tomorrow, I know it's going to be hard, but wait until tomorrow. Let him go to work, just pick up the necessities, and get out. Or, if there's a little baby, and she's being battered and bruised, I'd say, I just need to go and get the baby some milk, or I need to go and get... you just walk out with you and your kid and you just get out. But don't say I'm leaving you, because you'll end up dead. But this is something that they need to learn."*
- 2.5.24 The independent Chair asked whether, if someone like Sarah's mother, had known about the behaviours Brendan was using against Sarah, and had talked to her about it, Sarah would have listened? Sarah's mother agreed that it might have helped. If Sarah had seen something on TV, that might also have spoken to her about what she was experiencing.

Comments prompted by the Overview Report

- 2.5.25 Sarah's mother's feedback on the Overview Report particularly focused on Brendan's engagement with mental health services, and whether any agency, individually or together, could have done more both to engage with Brendan at the time, or to share information that would have enabled more to be known about Brendan's mental health.
- 2.5.26 Her questions have been addressed and added to the Report (see 5.2.3).

2.6 Information relating to Brendan

- 2.6.1 Brendan was aged 22 at the time of the homicide. He is British (white). Although he had worked since moving to Essex at the end of 2014, he had no recorded employment at the time of the homicide. He lived with Sarah. He had previously lived in Wiltshire, Oxfordshire and the West Midlands.
- 2.6.2 Appendix 2 presents Brendan's contact with agencies in chronological order.

2.7 General Practices (GP)

- 2.7.1 Brendan did not register with a GP in Essex; he was previously registered with three practices in Oxfordshire and Wiltshire and one in the West Midlands.
- 2.7.2 In April 2011 Brendan attended Elmtree General Practice (Wiltshire) and was recorded as reporting "*low mood and suicidal ideation*". The record stated that he had broken up with his girlfriend of three years and that police had been called due to his state of mind (see Thames Valley Police and Wiltshire Police, 3.8 & 3.9). Brendan was recorded as "*having plans*" and "*will do it [commit suicide] if left alone*". The GP contacted the mental health crisis team to make an urgent referral (see CAMHS, 3.10)
- 2.7.3 At the end of April 2011 Elmtree recorded receipt of a letter from the Swindon Child and Adolescent Mental Health Service (CAMHS) that they had seen Brendan and their assessment was that he was "*experiencing an adjustment reaction in the context of the ending of an intense relationship*" and that the community team were continuing support.
- 2.7.4 Late October 2012 Elmtree recorded a notification of Brendan's attendance at hospital for a deliberate overdose of paracetamol by Brendan (see Avon & Wiltshire Mental Health Partnership NHS Trust, 3.11).
- 2.7.5 Early November 2012 Brendan had an appointment at Elmtree about his mental health. The following was recorded: "*history of depression and deliberate self harm, most recently 1 month ago, admitted to hospital. Looking for work, low most days, girlfriend is 'his rock'. Anxious about relationship breaking down. Thoughts of self harm 1-2 days a week but no plans at present. Girlfriend is protective factor.*" The GP recorded an urgent referral for Brendan to the counsellor, and medication for Brendan for one week.
- 2.7.6 Brendan was seen by the same GP one week later at which Brendan was recorded as "*brighter, things ok at home, looking for work*". Two further weeks of medication were prescribed and the GP noted Brendan would "*rebook with counsellor*".
- 2.7.7 Late November 2012 Brendan saw the same GP again and was recorded as stating his mood was now stable, he had left home as his mum was arguing with

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- her partner, and he no longer wanted to see the counsellor because his girlfriend was his main support. He reported no thoughts of self-harm or suicide. Brendan called the GP the next day and stated he no longer needed medication.
- 2.7.8 Brendan missed his next appointment to review his mood, and spoke to the GP on the telephone on in December 2012. Brendan was recorded as reporting his mood being “*good*” at present, and was advised to attend the General Practice again if his mood worsened.
- 2.7.9 Brendan did not attend the surgery again.
- 2.7.10 Brendan was registered with Meadowside Family Health Centre (West Midlands) from August 2013 to September 2014; the only record was a notification from Darlington Hospital that Brendan had attended the Emergency Department accompanied by police. This was dated on their system as middle August 2013; Durham Constabulary records show that they accompanied Brendan to Darlington Hospital on the same day (see 3.12).
- 2.7.11 At the same time, Brendan was recorded as registering with Hawthorn Medical Centre (Wiltshire) at the end of August 2013. The next record is mid December 2013: “*records waiting to be sent. Removal to new HA [Health Authority]*”.
- 2.7.12 Brendan’s next attendance at a General Practice was at the end of August 2014 when he attended White Horse Surgery (Oxfordshire), and asked for counselling due to “*low mood*”. Brendan was provided with the details of the counselling service Talking Space and Brendan was recorded as saying he would self-refer.
- 2.7.13 The next day Brendan spoke with the same GP, having contacted Talking Space but still with concerns over his mental health. The record stated that he was coping and “*sounded OK*”. The GP called Talking Space who reported that Brendan had been feeling suicidal a few days ago and had planned to jump from a bridge but hadn’t done it. Brendan had reported two previous suicide attempts. He stated he was trying to get his job back and trying to help himself. The GP recorded that Talking Space had stated they would notify the General Practice as to whether they were going to organise psychiatric help. There were no further records in relation to this.
- 2.7.14 In September 2014 Brendan was again recorded as newly registered at Hawthorn Medical Centre in Wiltshire (see 3.7.11), and a FAST alcohol screen questionnaire was added to the system in which no concerns regarding Brendan’s alcohol consumption was recorded.
- 2.7.15 In September 2014 Brendan attended Hawthorn GP. Depression dating back to Brendan being 14 years old was noted, along with current thoughts of “*jumping under a train or stabbing himself in the head*”. It was recorded that Brendan

resisted these thoughts, and was requesting psychological support. The GP referred him to the Primary Care Liaison Team (see Avon & Wiltshire Mental Health Partnership NHS Trust, 3.11) on the basis of Brendan's high risk of suicide. The service spoke to Brendan while he was with the GP, and it was agreed that Brendan would contact the LIFT psychology service via the General Practice. (NB: the LIFT Psychology Service were contacted as part of this Review; they could find no record of Brendan accessing their service.)

- 2.7.16 Early October 2014 Hawthorn recorded that Brendan had not attended his counselling session. On contacting him, Brendan stated that he had forgotten the appointment; a new one was made which he later cancelled. This was Brendan's last recorded contact with this or any GP.
- 2.7.17 In October 2014 Hawthorn were contacted by the Public Defender Service, which requested a medical report and all medical notes for Brendan following an incident in which he had tried to jump from a building (see Durham Constabulary, 3.12). They also asked the GP to give an opinion as to whether pursuing a prosecution would be in the public interest. A letter was sent, and the GP gave their opinion that it would not be in the public interest to prosecute Brendan.

2.8 Thames Valley Police

- 2.8.1 Thames Valley Police attended a domestic abuse incident in 2006 involving an argument between Brendan's mother and her ex-partner. Brendan was recorded as being in the household. No offences were disclosed. A notification was sent to Children's Social Care. [Swindon Children's Social Care were contacted as part of the review and found no records for Brendan.]
- 2.8.2 Early April 2011 Thames Valley Police received a call from a member of the public who reported concerns about a person with whom they were talking online (via an online game), who was subsequently identified as Brendan. Brendan had told the caller that he had recently split up with his partner, and that he was going to go out of the house and kill himself.
- 2.8.3 Brendan told the caller that his mother was alive but that he did not speak to her. The caller continued to talk online to Brendan while speaking with police, and tried to gain more details that would identify Brendan and enable a police response.
- 2.8.4 Brendan informed the caller that he was aged 17 years and lived a few miles from Swindon, following which Thames Valley Police were able to locate him. Due to Brendan's location, Thames Valley Police contacted Wiltshire Police to attend the incident, as they were closer and would therefore get there faster. Thames Valley Police then attended and dealt with the incident alongside Wiltshire Police.

2.9 Wiltshire Police

2.9.1 Wiltshire Police Officers attended the Brendan's address following a request from Thames Valley Police, as outlined in the above section. Officers spoke to a male who identified himself as Brendan. The attending officers recorded that Brendan looked "*sheepish*" and that the concern over his suicide had reduced. Brendan was recorded as having been taken voluntarily to an Avon and Wiltshire Mental Health NHS Partnership Trust inpatient unit. (The Trust has no record of an inpatient stay by Brendan, or a visit by him on that date.)

2.10 Oxford Health NHS Foundation Trust: Child and Adult Mental Health Service (CAMHS)

2.10.1 Early April 2011 the CAMHS Consultant Clinical Psychologist met with Brendan and his mother, following an urgent referral from Brendan's General Practice (see 3.7.2). Brendan stated that he felt uncomfortable discussing everything with his mother present and so was seen alone. Brendan was recorded as feeling suicidal following the break-up of a relationship, and at risk of self-harm. A risk assessment and care plan was made and shared with Brendan and his mother. Brendan was offered support from the outreach service immediately, and an urgent psychiatric assessment was requested.

2.10.2 Brendan's mother reported that Brendan was booked to attend a camp, organised by his college as part of his course, which would delay the assessment. Brendan's mother agreed to discuss with Brendan and the camp organisers the safety issues regarding Brendan going away when displaying high-risk behaviours. The team checked this, and a plan was put in place with Brendan and the staff running the camp.

2.10.3 A home visit was conducted by the outreach service, prior to Brendan leaving for the camp. An assessment of Brendan's mental state was conducted. Brendan was recorded as appearing to be "*low in mood*"; with concentration, appetite and sleep noted as poor but with no current suicidal plans. Brendan reported having self-harmed for the last time around 18 months prior, and that he had sought help about this from his college counselling service. Techniques for managing his emotions were provided and discussed with Brendan. Brendan's protective factors were listed as a good friendship group, being able to talk to his mother, and that he was making future plans about finishing college and joining the fire service.

2.10.4 A second home visit was made with Brendan and his mother the next day. Brendan reported that he had been upset after a phone call with his ex-girlfriend but had managed this by talking to a friend. The service also met with Brendan's mother, and discussed arrangements regarding the upcoming trip. There were further discussions on distraction techniques for Brendan to use in managing his

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- emotions. An appointment for the psychiatric assessment was booked for mid April 2011.
- 2.10.5 The service called Brendan to offer a home visit; Brendan declined as he was busy getting ready for the trip. Further telephone calls and texts were made from this point on to check on Brendan's wellbeing while he was away and to offer support.
- 2.10.6 Mid April 2011 the service called Brendan to find out how he was after the trip. Brendan reported that it had been good, a good distraction and had helped him to not think about his recently ended relationship, and that he had made friends. His mood had been low since the day before as his ex-girlfriend had changed her mobile phone number and removed him from her social media contacts, which meant he could no longer contact her. Brendan was recorded as being depressed and upset following the break up, and that any harmful behaviour he described was directed at himself.
- 2.10.7 The Consultant Psychiatrist conducted the psychiatric assessment. Brendan was recorded as not "*pervasively*" low in mood, but continued to have suicidal thoughts such as jumping in front of a train or jumping from a building. The main concerns were that he might act impulsively in a crisis. He stated that since he had returned from his trip, he had had contact with his ex-girlfriend during which he "*smashed up her laptop*". He reported that he had found this "*freed up a lot of angry feelings*". The assessment noted "*interdependence issues*" with the ex-girlfriend.
- 2.10.8 Brendan and his mother were spoken with together, and also separately. When Brendan's mother was spoken with alone, she disclosed that she had "*heard [from a third party] that Brendan had tried to strangle [his ex-girlfriend] in the past*" but that she did not think it was true. Brendan was asked about this, and he strongly denied any violence in the relationship.
- 2.10.9 The assessment concluded that Brendan was experiencing an adjustment reaction to the end of the relationship, and that there was no enduring mental illness. Brendan stated that he was finding the outreach service to be supportive and helpful.
- 2.10.10 As Brendan would shortly turn 18 years old, a possible (i.e. if required) referral to adult mental health services was discussed; Brendan was happy for this to happen.
- 2.10.11 A discussion was held between the Consultant Psychiatrist and the outreach service to make plans for supporting Brendan through ongoing outreach. A risk plan was agreed relating to the risk identified: "*impulse serious act of self harm not in the context of a mental illness*".

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- 2.10.12 A telephone call was made on at the end April 2011 to arrange a home visit for the next day. At that visit, Brendan was recorded as feeling low over the weekend, but following conversations with a friend's mother, was feeling more positive. His sleep, appetite and energy were back to normal. A crisis plan was made in which Brendan would telephone the GP out of hours if he was feeling overwhelmed, in order to get CAMHS support if required; and to continue to talk to friends and family when possible.
- 2.10.13 A further telephone call was made to Brendan, in early May 2011 in which Brendan described feeling good. No concerns were noted.
- 2.10.14 Brendan's college called the service early May 2011; Brendan's "tutor" reported knowing Brendan well, described him as "*popular and well liked*", and stated that there were no problems. The "tutor" agreed to support Brendan with extending deadlines to help him to complete the course. This support was confirmed as helpful to Brendan's wellbeing in a letter from CAMHS to the college at the end of May 2011.
- 2.10.15 At a home visit in early May 2011 the service recorded that Brendan's "*mood [was] much improved*" and that he was making plans for returning to college. He reported being able to be in contact with his ex-girlfriend with no adverse feelings or reactions. Brendan continued to use the distress tolerance techniques to cope with his emotions, and planned to see the college counsellor when he returned.
- 2.10.16 A joint meeting of CAMHS and adult mental health services was held in May 2011, to evaluate whether Brendan needed to transition to adult services when he turned 18 shortly. It was agreed that Brendan would not transfer to adult services; rather that CAMHS would gradually withdraw support and discharge Brendan when he turned 18.
- 2.10.17 This plan was made as Brendan was reporting feeling better, with no suicidal thoughts and feeling ok most of the time. When he didn't feel ok he felt upset or angry. It was noted that Brendan strongly denied any past violence to his ex-girlfriend. The service assessed that Brendan's "*adjustment disorder [was] resolving*" and there were no apparent risk factors. A note was included of "*[s]ome dependence issues evident*".
- 2.10.18 In May 2011 the service made a home visit, and continued positive improvement of Brendan's mood and behaviour were noted. This was confirmed during a telephone call later in the month.
- 2.10.19 The last visit to Brendan was made at the end May 2011. Brendan was provided with information about adult mental health services in case he needed them in the future, and it was noted that he had no need for them at that time. Brendan was discharged from the service.

2.11 Avon and Wiltshire Mental Health Partnership NHS Trust

- 2.11.1 The Trust had brief contact with Brendan during his time under the care of CAMHS in April 2011 (see 3.10.16).
- 2.11.2 Brendan saw the Mental Health Liaison Team mid October 2012 after he had been admitted to the Great Western Hospital in Swindon following an overdose of 16 ibuprofen and 48 paracetamol.
- 2.11.3 He received a full psychosocial assessment by the Mental Health Liaison practitioner, who recorded that it had been an impulsive overdose with no clear suicidal intent and Brendan had sought prompt help. The end of his relationship with his girlfriend had triggered the overdose. It was recorded that Brendan had self-harmed by cutting on two occasions when he was 14 years old, and also that he had stabbed himself after a relationship breakdown three years previously (i.e. aged 16). He was with his ex-girlfriend when he took the overdose and she called an ambulance within minutes. Brendan was adamant he would not do this again and was recorded as having given "*plausible reasons as to why*".
- 2.11.4 On assessment Brendan described his mood as happy and there was no evidence of low mood at that time. His sleep pattern was good as was his appetite; he was keeping active by training and cycling and had future orientated plans. There was no evidence of any abnormal perceptions or thought processes. Brendan did identify he had experienced thoughts of harming himself, but that these were less likely to occur when he was in a relationship. Brendan's risk to himself or others was assessed as low.
- 2.11.5 The assessment did not identify any enduring mental illness: the lack of a job, and a relationship break up, were recorded to have triggered the overdose. Brendan was advised to access counselling services through primary care and a Samaritans call was arranged for the following week. No indication of a need for secondary mental health services was recorded.
- 2.11.6 Two years later, in September 2014, the Trust's Primary Care Liaison Service (PCLS) received a referral from Brendan's GP (White Horse Surgery, see 3.7.15) for assessment. The Duty Nurse contacted Brendan the same day. Brendan was recorded as telling the nurse that he was OK at the moment, and that he had just got off the phone from a job interview, which he was hoping to get. He informed the nurse that if he could get a job then he would be fine, and did not need any medical input, just psychological.
- 2.11.7 The Duty Nurse advised Brendan to contact the LIFT Psychology Services. (NB this service was contacted as part of the Review and they had no record of Brendan contacting them.) Brendan later called the nurse back to confirm that he had booked an appointment with IAPT (Improving Access to Psychological

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Therapies). It was agreed that if he needed help before that, he could contact the service again, and if the intervention from IAPT was not helpful in addressing “*his past trauma*” he could contact his GP who could refer him to PCLS again. Brendan was then discharged from the service.

2.12 Durham Constabulary

- 2.12.1 Durham Constabulary's involvement with Brendan took place in August 2014, when they were called to a hotel in Darlington. Brendan had met with a local 16-year-old female; after spending the night together in the hotel, the female had left the hotel around 11.45am. Following this Brendan wrote a suicide note stating he had had a fantastic night but intended to throw himself from the hotel window. Brendan then sat on the ledge outside the fourth floor room, resulting in police being called.
- 2.12.2 The incident lasted approximately two hours, at the end of which Brendan was persuaded to come back inside by police negotiators.
- 2.12.3 Officers then took Brendan to Darlington Memorial Hospital for a mental health assessment (see Tees, Esk and Wear Valleys NHS Foundation Trust, 3.13). Following the Crisis Team's decision that there was no need for further intervention, Brendan was arrested and charged with causing a public nuisance and bailed to attend court. The CPS later discontinued the case (see the contact made to Brendan's GP Hawthorn by the Public Defender Service, 3.7.17).
- 2.12.4 The officer in the case submitted an adult concern referral for Brendan that was sent to and discussed with Adult Social Care Services. Following discussion the referral was not progressed, as no mental health issues had been identified. Brendan had not given his consent to the referral and so no additional support or information could be provided to him.
- 2.12.5 A Children's Social Care referral was made in relation to the 16-year-old female.

2.13 Tees, Esk and Wear Valleys NHS Foundation Trust

- 2.13.1 The Mental Health Liaison Team assessed Brendan after he had been brought to Darlington Hospital by Durham Constabulary (see 3.12.3). Brendan was assessed to have ongoing issues with anxiety and social discomforts but not to be acutely mentally unwell. It was noted that Brendan had attempted to secure his own rescue by telling a third party what he was doing (this was the girl he had travelled to see).
- 2.13.2 Following the assessment Brendan was discharged. Brendan agreed to gain future help in the area he lived (Swindon), including to register with a GP. Brendan was given literature about support services in case his mental health deteriorated.

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2.13.3 A Multi-Agency Safeguarding Hub (Children’s Safeguarding) referral was made for the 16-year-old female Brendan had travelled to Darlington to see.

2.13.4 One week later at the end of August 2014 the Team made a follow up phone call to Brendan, and it was recorded that Brendan said he had registered with a GP (White Horse surgery, see 3.7.12) and was waiting for a call from a therapist the next day. Information on the assessment completed with Brendan was recorded as having been sent to the GP (recorded by Meadowside GP with the date 2013, see 3.7.10).

2.14 New College Swindon

2.14.1 Brendan attended New College Swindon from September 2009 to June 2011, studying for qualifications in Public Services.

2.14.2 The College have no records relating to the contact between CAMHS and Brendan’s “*tutor*”.

2.15 West Midlands Police

2.15.1 At the end of June 2013 West Midlands Police were called to a shopping centre in Solihull by security due to a “*male in blue approaching shoppers*” and that he looked like he was harassing people.

2.15.2 The male was identified as Brendan, and when spoken with by officers he stated that he was “*just trying to make people smile*”.

2.15.3 No offences were disclosed and the incident was classified as “*anti-social behaviour / nuisance*” and closed.

2.16 Information from Brendan

2.16.1 Brendan was interviewed in the prison in which he is held.

2.16.2 In the interview, Brendan maintained an argument of self-defence in relation to the homicide, as he had done at the trial. Brendan denied any violence or abuse against Sarah, and denied being controlling.

2.16.3 Brendan reported that he and Sarah had been friends for a long time, having met through an ex-girlfriend of Brendan’s when he was living in Wiltshire and Sarah lived in another county. They kept in contact through telephone calls and social media. Brendan stated that he and Sarah were very close, in particular because they had both struggled with depression and self-harm.

2.16.4 Brendan stated that the relationship with Sarah started after he had moved in with her in Essex. He reported having moved to Essex because he had become homeless in Oxfordshire, and needed a fresh start.

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- 2.16.5 Brendan talked about one incident in which he told Sarah that he wasn't happy with a top she was wearing, that he said was revealing. Brendan felt that this incident had been reported to Sarah's friends in such a way that made it seem that he was controlling, which he denied.
- 2.16.6 When Brendan was living with his mother, he had a difficult relationship with one of her partners, who Brendan stated was bullying towards him. Brendan had also experienced the death of a sibling when he was very young, and reported that this had had a significant impact on his mental health and life ever since.
- 2.16.7 Brendan did not feel that he could have been supported any differently by any of the agencies he had been in contact with, because he felt that all of his problems related back to the loss of his sibling.

3. Analysis

3.1 Domestic Abuse/Violence Definition

3.1.1 The government definition of domestic violence and abuse (2013) is:

“Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass, but is not limited to, the following types of abuse: psychological; physical; sexual; financial; and emotional.

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.

Coercive behaviour is: an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim.”

3.1.2 Information gathered for the police investigation showed that Brendan had used abusive controlling behaviours towards Sarah. Sarah’s mother also told the Review about some behaviours of Brendan’s that Sarah had told her about that would be defined as abuse: telling her what she could and could not wear; making her financially responsible for their joint life and all his needs (stopping her from saving and planning for her future); ‘play fighting’ which at the time seemed innocent; all of which, in hindsight, take on different meaning for Sarah’s mother.

3.1.3 This Review also received information that Brendan had used abusive behaviours towards ex-girlfriends: he had smashed a girlfriend’s laptop, and had allegedly attempted to strangle her; he had taken an overdose in front of another girlfriend.

3.2 General Practices (GP) – Sarah

3.2.1 Sarah asked for help from her GP on two occasions regarding her low mood and self-harm. In both cases the GP acted promptly by referring Sarah to community mental health services, in addition to prescribing anti-depressant medication.

3.2.2 On the first occasion (September 2009) the GP explored Sarah’s issues with her in relation to her family and mood, and recorded actions that Sarah was advised to pursue, for example sport and talking to her father, which is good practice. Despite this, there was no apparent follow up with Sarah as to how her mood had improved or otherwise with the counselling she was feeling; although a review was mentioned there was no record of it. The GP could have done this at any point,

but particularly on receipt of the information that Sarah had finished counselling with Safe Speak (May 2010); and when she attended reporting difficulties at home in August 2010.

- 3.2.3 On the second occasion, the GP was initially proactive with Sarah and saw her on three occasions. Despite this the GP did not follow up with Sarah when she did not attend her appointments with the mental health service. This is particularly notable in light of Sarah reporting (March 2012) that she was not clear on what one of the letters was asking of her. The GP should have maintained responsibility for Sarah's mental health until such time as she was (or if she were) taken on by the mental health service, and the lack of follow up both in response to the letter Sarah did not understand and the fact that Sarah attended neither appointment is unfortunate.
- 3.2.4 Sarah moved away to Essex shortly after this. We cannot know what impact this lack of follow up had on Sarah, but we can speculate that it could have put her off from seeking help in the future, either for her own mental health or about her relationship with Brendan.
- 3.2.5 A recommendation (2) is made for NHS England to feedback to all the General Practices on the learning from this Review.

3.3 North East London NHS Foundation Trust

- 3.3.1 Sarah's attendance with this service was brief, and some time before her relationship with Brendan was understood to have started. No concerns were noted during her contact.
- 3.3.2 The letter to this Review from NELFT notes that at that time, Sarah was asked about drug and alcohol use and any mental health issues, and none were noted. Sarah was also asked about current relationships, and it was recorded that she was not in one at that time.
- 3.3.3 NELFT informed the Review that processes have since changed in relation to identifying possible domestic abuse/violence:
- “Sarah would have been asked whether she was in a relationship and if sexually active. Now all clients are asked whether there are any issues at home and if the client is in a relationship then directly asked whether there are any issues within this. If it is identified that there are issues of domestic violence then appropriate referrals are made, again considering whether any safeguarding concerns identified. If safeguarding concerns are identified these are raised via the Trust and local policies/procedures.”*
- 3.3.4 The DHR Panel welcomed this development, as engagement with sexual health services offers a good opportunity for routine enquiry about domestic

abuse/violence. The DHR Panel discussed the need for adequate training of professionals in carrying out routine enquiry in a safe and supportive way. It was noted that the service provider for sexual health services in Basildon has changed, and a recommendation (1) is therefore made to ensure that this practice is also in place with the new provider, and other commissioned services.

3.4 General Practices (GP) – Brendan

- 3.4.1 Brendan's contact with his GPs in relation to his mental health was notable given his young age. He attended repeatedly with mental health issues ranging from 'low mood' to suicidal thoughts, starting with Elmtree surgery in April 2011 when Brendan was aged 17 years.
- 3.4.2 Brendan registered with four different General Practices in this time, and with each one (with the exception of Meadowside) he asked for psychological help. On each occasion with Elmtree, White Horse and Hawthorn, referrals were made or information was given according to the specific report made by Brendan: i.e. whether it was 'low mood' or suicidal intentions.
- 3.4.3 Appropriate action was taken by Elmtree in response to Brendan's stated intentions of committing suicide in April 2011, with a referral being made to the psychiatric team that led to Brendan receiving support from the Child and Adolescent Mental Health Service (CAMHS, see 4.7).
- 3.4.4 Following receipt of the notification that Brendan had attempted suicide in October 2012 (with the notification recorded on the system on 26 October) there was no specific follow up apparent by Elmtree GP, although the overdose was discussed in Brendan's next appointment in November 2012. It would have been good practice for the GP to be more proactive with Brendan following this notification, rather than waiting for his next appointment. Shortly after this Brendan reported feeling much better. The GP offered further help, which was good practice; Brendan declined.
- 3.4.5 The Meadowside GP's only record for Brendan is the receipt of a notification from Darlington Hospital regarding Brendan's attendance following his threats to jump from the hotel. There is no evidence of any follow up, or any appointments at all with Brendan prior to or following this notification, which given the seriousness of his action in Darlington is concerning. The record of the notification was dated a year earlier than the incident, and this error may have led the GP to believe the attendance to not be recent.
- 3.4.6 Brendan made two references to a girlfriend to Elmtree but none to the others. The first reference followed the Police attendance for Brendan's threats of suicide in April 2011 (age 17), when he told the GP that the trigger for his threats was having broken up with his girlfriend of three years.

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- 3.4.7 The next was in November 2012 (age 19) following the suicide attempt on 14 October. The GP recorded Brendan as describing his girlfriend as “*his rock*”, but that he was anxious about the relationship breaking down. The GP recorded that Brendan’s girlfriend was a protective factor in relation to Brendan’s low mood and thoughts of suicide.
- 3.4.8 In both of these instances the GP did not consider the potential risk to Brendan’s girlfriend in light of Brendan’s threats of suicide. In particular in the first instance, when Brendan was 17, the GP could have assumed that Brendan’s girlfriend was also a child and may have been in need of intervention in relation to the risk Brendan may have posed. (See more in 5.2.2.)
- 3.4.9 The NHS England IMR recognises these missed opportunities and makes recommendations to improve the awareness of General Practitioners in relation to risk of harm to others, particularly in relation to intimate relationships:
- (a) To spread the learning from this incident to General Practices to try to improve the awareness of GPs in relation to risk of harm to others, particularly in relation to intimate relationships and the risk factors for violence in a relationship. To spread the learning from this incident to General Practices to increase recognition that reported violence in an under-18 relationship should be considered within a child safeguarding framework.
 - (b) To share this learning through: Incorporating the learning points into the quarterly Quality and Safety Learning Bulletin that is distributed to all General Practices in the Eastern region; and through the local and national named GP/Primary Care Professional forum.
- 3.4.10 Ideally, each General Practice would have sought from Brendan the details of his previous GP, and requested his history from them so that they had all information about Brendan’s history of accessing health care. This should have included notifications and contacts with all the mental health services. This Review cannot know what information Brendan gave to each new GP that he registered with nor whether they requested his medical history and received it.
- 3.4.11 The final General Practice that Brendan registered with was Hawthorn. Had they gathered all of Brendan’s medical history, and this had included his contact with mental health services, they were in a position to identify his fluctuating mental health and to reach out to him to offer support. We cannot know if he would have accepted it. Unfortunately as Brendan did not register with a GP in Essex, this opportunity did not arise again.
- 3.4.12 An additional recommendation (2) is made in this Review for the specific learning from this case, as outlined in this section, to be shared and discussed with the General Practices involved.

3.5 Thames Valley Police

- 3.5.1 Thames Valley Police's first involvement with Brendan, in 2006, was responded to appropriately, in particular that a notification was sent to Children's Social Care.
- 3.5.2 On receiving the call from the member of the public in April 2011 Thames Valley Police responded promptly in response to Brendan's suicide threat, and it was good practice for them to involve Wiltshire Police upon realising that they were closer to Brendan's location.
- 3.5.3 Thames Valley Police recognise that this incident should have generated a safeguarding response, in this case child safeguarding as Brendan was aged 17 at the time. The officer in the case should have created a Child Protection Report which would have gone to the Child Abuse Investigation Unit for review and action if appropriate/necessary.
- 3.5.4 Since this incident, the process has changed and a specific report is now created that is reviewed by a MASH (Multi-Agency Safeguarding Hub) team leading to appropriate safeguarding action. Officers have received training on this and work is ongoing to embed a force-wide approach to safeguarding (including the implementation of an identification and recording tool; training; and a performance and audit framework).

3.6 Wiltshire Police

- 3.6.1 Wiltshire Police responded quickly when asked to attend by Thames Valley Police. They located Brendan promptly and were able to identify that the risk was not as significant as first thought.
- 3.6.2 Brendan was offered support from external agencies and decided he wanted to attend a mental health unit voluntarily. While the Trust have no record of an inpatient stay, Wiltshire Police records suggest that proper procedure was followed.

3.7 Oxford Health NHS Foundation Trust: Child and Adolescent Mental Health Service (CAMHS)

- 3.7.1 CAMHS responded promptly to the urgent referral made for Brendan by his GP. While awaiting the assessment, Brendan's risks were identified and managed, and the outreach service maintained frequent contact with both Brendan and his mother to ensure his safety, as far as possible, while he was away on the pre-arranged camp.
- 3.7.2 The assessment was carried out in line with procedure and was a thorough review of Brendan's mental state and risk. Risk and care plans were made and reviewed

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- with Brendan and his mother, primarily addressing the identified risk Brendan posed to himself.
- 3.7.3 The Outreach Worker developed a good relationship with Brendan and followed an evidence-based model for supporting Brendan to manage his emotions and reactions to situations. The worker engaged with Brendan to support him in working towards going back to college and planning for his future.
- 3.7.4 There was proactive liaison with Brendan's GP and College. The engagement with Brendan's tutor ensured that he would be supported as he returned to his course.
- 3.7.5 The IMR author highlights the statement made by Brendan's mother that she had heard from a third party that Brendan had allegedly attempted to strangle his ex-girlfriend. The Consultant Psychiatrist appropriately followed this up with Brendan, who denied using any violence or aggression in the relationship. The IMR author however states that it would have been appropriate to consider the ex-girlfriend's safety, to ensure that she was protected if necessary and gain clearer information about Brendan's behaviour in relationships, which could have impacted on the way in which Brendan was worked with.
- 3.7.6 The IMR author notes that this course of action may have been difficult in light of appropriate information sharing and the fact that Brendan strongly denied the allegation. Nevertheless an IMR recommendation is made to ensure that CAMHS staff "*consider the risks of domestic abuse to their clients and also those people associated with their clients. Domestic abuse training for CAMHS staff has been highlighted in this Domestic Homicide Review and will form part of the Safeguarding Children Work Plan for 2015/16.*"
- 3.7.7 It would also have been appropriate for the Outreach Worker and other staff involved with Brendan to address his abusive behaviours and explore attitudes towards his relationship. In addition to the alleged attempted strangulation, Brendan stated that he had "*smashed up*" his ex-girlfriend's laptop, and "*dependence*" issues were noted. Further exploration with Brendan should have followed on his attitude to relationships, other abusive behaviours he may have been exhibiting (whether he acknowledged them as abusive or not). Advice could have been sought from a local domestic abuse perpetrator programme, or from Respect (<http://respect.uk.net>) if a local service was not in place. A recommendation (5) is therefore made.
- 3.7.8 A recommendation is included in the IMR to ensure that record keeping is robust, accurate, timely and maintained to the highest standard. Improvements to practice have been made since the time that Brendan was engaged with the service, and these are audited.

3.8 Avon and Wiltshire Mental Health Partnership NHS Trust

- 3.8.1 During his contact with the service following an attempted overdose in October 2012, Brendan received a full assessment and was provided with information on appropriate services when he was identified as not being in need of secondary mental health services. Brendan was assessed as a low risk of harm to others; this assessment did not recognise the risk Brendan may have posed to his ex-girlfriend (or future partners) in relation to his extreme response to the relationship ending. Had the Trust recognised the risk Brendan posed to partners (as suicide intention is a recognised risk factor for domestic abuse, see 5.2.2) they could have taken action to refer Brendan to an appropriate local or national service, and considered a response to Brendan's ex-girlfriend to ensure her safety.
- 3.8.2 Brendan's contact on this occasion was as a result of an attempted suicide through an overdose. While the number of tablets he took would not have killed him, they could have made him seriously ill; regardless, the seriousness of his action could have warranted a response that demonstrated more professional curiosity, and certainly could have led to engagement with Brendan by secondary mental health services. Although Brendan did not receive a diagnosis at that point, this contact was very brief. Had Brendan not been discharged from the service so quickly, a longer process of observation and analysis could have led to a more proactive and intensive support for him, in light of the history he gave of self harm and previous suicide attempts.
- 3.8.3 The Primary Care Liaison Service (PCLS) that Brendan accessed in September 2014 (two years later) is the single point of access to mental health services in Swindon. The team takes referrals from primary care services (mainly GPs) or offers signposting advice if a referral is not appropriate. When a referral is accepted the service makes an assessment of whether the service user requires secondary care mental health input (and as a result transfer their care to that service); and where this is not appropriate, to make recommendations to the service user and their GP around what services and medication they can access within primary care.
- 3.8.4 The latter was the response given to Brendan on this occasion, and Brendan was advised to contact a primary care psychology service (LIFT); Brendan referred to having made an appointment "*with IAPT*"; LIFT deliver these services in Swindon. They were contacted as part of this Review, and had no record of any contact with Brendan. The PCLS Nurse who spoke with Brendan did invite him to contact the service again if he needed to, before discharging him back to his GP.

3.9 Durham Constabulary

- 3.9.1 Following Durham Constabulary's involvement with Brendan on the incident in August 2014, good practice was followed through referrals being made both for Brendan (to Adult Services) and to Children's Social Care for the 16-year-old female who had accompanied him to the hotel. The adult services referral was an appropriate process to follow, given the extreme nature of Brendan's behaviour in this incident.
- 3.9.2 The Adult Services referral for Brendan was triaged with the senior practitioner from Darlington Adult Services within the MASH (Multi-Agency Safeguarding Hub). It was not felt to require further intervention because Brendan had been provided with appropriate support via Tees, Esk and Wear Valleys NHS Foundation Trust and a mental health assessment had been completed that deemed that he did not have any immediate mental health needs. As there was no physical or mental impairment identified Brendan was not eligible for social care intervention. The service would not provide additional support unless this was requested and consent had been given. Brendan had not given his consent.

3.10 Tees, Esk and Wear Valleys NHS Foundation Trust

- 3.10.1 Given that the Trust's involvement with Brendan was not in the area in which he lived, an appropriate response was provided in ensuring that Brendan accessed support when he returned home. A follow up call was made to ensure that Brendan had acted on the advice given, and he confirmed that he had registered with a GP and was accessing counselling. The Trust then sent their assessment information to the GP, which would have provided Brendan's GP with more information in order to support Brendan; unfortunately it was sent to Meadowside General Practice, rather than the Practice that Brendan then attended, so the information was not available to the GP he saw.
- 3.10.2 The Trust also showed good practice by making a children's safeguarding referral for the 16-year-old female who had accompanied Brendan to the hotel.
- 3.10.3 The actions taken by the team were appropriate in relation to the assessment and the follow up was in line with trust policies and procedures.

3.11 New College Swindon

- 3.11.1 Brendan's attendance at the College indicated no areas of concern. His attendance, punctuality and performance records were adequate. The IMR author interviewed two members of staff who had been involved with Brendan's time in the college.

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- 3.11.2 New College records, and the two staff interviewed for the IMR, were not aware of either the break-up of a relationship or any mental health issues that Brendan was experiencing during his time at the college. The College recorded no contacts from other agencies involved with Brendan. The CAMHS IMR indicates that there was contact between the service and Brendan's "tutor" at the college, to ensure he was supported to return to and complete his course. As there are no official records of this contact, the College conclude that this contact was with a lecturer of Brendan's. A recommendation (7) is made below to address the fact that the lecturer's contact with CAMHS and information about their involvement with Brendan should have been recorded.
- 3.11.3 One member of staff interviewed for the IMR described Brendan as "*a good student when he was working, polite, someone who engaged in activities*". His attendance at times was poor and Brendan produced many excuses, including ones related to travelling to see a girlfriend by train, for which Brendan needed to leave early or come in late. The staff member described Brendan as a "*loner*" who did not mix with other students. It should be noted that the CAMHS IMR records that the "tutor" they spoke with described Brendan as "*popular and well liked*".
- 3.11.4 The other member of staff interviewed for the IMR referred to Brendan as "*a loner*" and also to his problematic attendance in relation to travelling to see a girlfriend, and in addition that he would leave the classroom in order to take phone calls from that girlfriend. The IMR notes that in personal tutor sessions Brendan did not discuss his personal life; however this would have been an ideal opportunity to attempt to explore with Brendan the nature of his relationship, as it was having an impact on his studies. Referral, signposting or some level of intervention around his apparent dependence on his girlfriend could then have followed, if Brendan had chosen to talk to the personal tutor.
- 3.11.5 This member of staff described Brendan's behaviour as "*the standard adolescent behaviour of one who has got their first real girlfriend*"; categorising it as such appears to have led to opportunities to explore Brendan's relationship not being taken.
- 3.11.6 The College have outlined that domestic violence is included in Safeguarding updates, which staff have every 3 years. In addition staff have attended workshops that have gone into more detail on this topic, led by the manager of the local women's refuge. This included the nature of abuse in teenage relationships, which is welcome but was a one-off. Given the age of the students at the college, and what research shows about the prevalence of domestic abuse in young people's relationships, a recommendation (6) is made for further action to be taken.

3.12 West Midlands Police

- 3.12.1 West Midlands Police involvement with Brendan was very brief and did not lead to further police action. The DHR Panel discussed whether officers should have responded more proactively to Brendan's unusual behaviour but concluded that given the frequency with which many police forces deal with incidents such as this, and the fact that Brendan was not harming anyone, the category of 'anti-social behaviour / nuisance' was to be expected.
- 3.12.2 Ideally Brendan could have been provided with information about services in case he needed support, but officers could not have been expected to have access to this while on patrol.

3.13 Diversity

3.13.1 Gender and Age

Being female is a risk factor for being targeted by a perpetrator of domestic abuse, making this characteristic relevant for this case, Sarah having been a victim of domestic abuse from Brendan.

Young women in particular have been identified as at high risk of being targeted by domestic abuse perpetrators²; Sarah was 21 when (it is estimated) her relationship with Brendan started. In addition to being at risk of being targeted by a perpetrator, some studies have shown that young people can have views that support the use of abuse and violence by intimate partners. Sarah's mother told the Review that she felt that Sarah would not have associated Brendan's controlling behaviours with the term 'domestic abuse' and probably did not see that she was in any danger from him as a result of them.

One research study³ found that the following views were prevalent amongst the young people interviewed:

- Violence between young people isn't real violence
- Men are naturally violent
- Much of men's violence against women is justified, for example because it takes place in an intimate relationship or because the woman is perceived as deserving it.

² Office for National Statistics (2015) *Crime Survey of England and Wales: Violent Crime and Sexual Offences – Intimate Personal Violence and Serious Sexual Assault 2013/14*

³ Lombard, N. (2011) 'Young People's Attitudes about Violence, Centre for Research on Families and Relationships' Briefing 54; findings reflect earlier studies e.g. NSPCC/Sugar (2006) and EVAW/ICM (2006)

A study from the NSPCC⁴ found:

- Following an experience of physical violence from an intimate partner: “*the most frequent, indeed only, source of advice and support accessed by young people was friends*”. More help seeking was evidenced when emotional violence was experienced, and again it was friends who were the source of that support.
- 25% of girls and 18% of boys reported some form of physical partner violence. 72% of girls and 51% of boys reported some form of emotional partner violence.
- The most commonly reported forms of emotional violence, irrespective of gender, were “*being made fun of*” and “*constantly being checked up on by partner*”.
- Girls reported a more significant, negative, impact on their wellbeing than boys in relation to both physical and emotional violence.

We do not know exactly what Sarah was experiencing in her relationship with Brendan (albeit we know some of the behaviours as outlined in the feedback from her mother), or how she perceived it, but the above research suggests that it was possible she did not label it as ‘domestic abuse’ and may not have seen mainstream services as a source of support. She may also not have understood the risk she faced in ending the relationship. It is also possible that she understood the situation, but was too fearful to seek help. This is discussed further in section five (5.2.1).

3.13.2 *Race; religion and belief; disability; sexual orientation; gender reassignment; marriage / civil partnership; pregnancy and maternity*

No information was presented within the review to indicate these were issues.

⁴ Barter, C., McCarry, M., Berridge, D. and Evans, K. (2009) *Partner Exploitation and Violence in Teenage Intimate Relationships* NSPCC

4. Conclusions and Recommendations

4.1 Preventability

- 4.1.1 No agency in Essex, or elsewhere, had any contact with Sarah or Brendan in the six months prior to the homicide. Sarah's mother reported that she had no idea that Brendan posed any risk to Sarah. Therefore in the immediate time before the homicide occurred, it could not have been prevented.
- 4.1.2 It may be that Sarah was not aware of the dynamics of domestic violence/abuse, and the risk she faced as a result when trying to end the relationship; if she had, perhaps she would have sought help before doing so. Her mother's input to the Review suggests that Sarah may not have seen Brendan's behaviour as abusive; or if she did that she did not communicate this to her family directly. Sarah may have understood the risks but felt too fearful and isolated to seek help. If Sarah had made contact with an agency such as Changing Pathways she could have received support to reach safety. Unfortunately this would have required Sarah to recognise herself as someone in need of such a service, and know where to go for that support; or for a family member, friend or colleague to know where to go and to tell her. Sarah's mother told the Review that Sarah did not often seek help from agencies.
- 4.1.3 This opportunity for early intervention with Sarah would have had the potential to prevent the homicide, but the number of steps required for Sarah to get to that point is notable and unfortunate.
- 4.1.4 If Brendan had been recognised as a perpetrator of domestic abuse (most pertinently by CAMHS during his contact with them) and his use of abusive behaviours had been challenged and worked on, it is possible he would have chosen not to use abusive behaviours and for future relationships to be healthy ones, which may have impacted on his future actions. Ultimately, only one person is responsible for the homicide, and that is Brendan.
- 4.1.5 Sarah's mother felt strongly that, had Brendan received more proactive mental health intervention during the time when he was threatening and attempting suicide (2012-2014) then the outcome could have been different. There were many factors influencing the care Brendan received: the low level of perceived risk to himself; that he was not seen as a risk to others; and that he was assessed to be in need of primary mental health care, which is voluntary, and not in need of secondary health care, which would have been more of an intervention. This Review cannot say, had any of these been different, that he would not have killed Sarah.

4.2 Issues raised by the review

4.2.1 Awareness/recognition of domestic abuse, including controlling behaviours

- (a) The Government definition of domestic violence (see 4.1.1) changed to include ‘coercive control’ in 2013. The change was made in order to “*highlight the importance of recognising coercive control as a complex pattern of overlapping and repeated abuse perpetrated within a context of power and control.*”⁵
- (b) This followed a long period of campaigning by the domestic violence/abuse sector to change the understanding of domestic violence/abuse from something that centred on physical violence, to one that saw control and coercion as at the heart of a perpetrator’s tactics.
- (c) This Review did not uncover any evidence of Brendan being physically violent to Sarah; but it was reported that he was controlling and that this was part of the reason for Sarah wanting to end the relationship. The Review did uncover allegations of Brendan using physical violence against a former girlfriend. We cannot know whether Sarah recognised these controlling behaviours as ‘domestic abuse’. We know from research and the experience of specialist services that many victims do not recognise coercive and controlling behaviours as constituting domestic abuse (particularly if there is no physical aggression or violence used by the perpetrator), although awareness is growing since the change to the law outlined above.
- (d) The DHR Panel considered that Sarah, her friends, family and colleagues, while recognising that Brendan’s behaviours were not right, might not have recognised her as a ‘victim of domestic abuse’ or that a ‘domestic abuse’ service could meet her needs. This was reflected in the Chair’s interview with Sarah’s mother. While there has been increasing awareness of the abuse and violence used by some young men (and women) in their intimate relationships, that knowledge and awareness is not always found amongst young people themselves (see 4.13.1).
- (e) We can now see the risk Sarah faced when she stated she wanted to end the relationship. Research shows that separation is often the riskiest time for domestic abuse victims, with one study showing that 76% of the homicides reviewed having involved separation⁶. But we cannot know if Sarah

⁵ *Information for Local Areas on the change to the Definition of Domestic Violence and Abuse*, Home Office 2013

⁶ Richards, L. (2003), *Findings from the Multi-agency Domestic Violence Murder Reviews in London* ACPO Homicide Working Group

understood the risk herself, or if she did how she felt in terms of taking action, or whether those around her (family, friends, or colleagues) had access to that information: feedback from her mother suggests that there were no concerns for Sarah's safety in ending the relationship. This may be due to a lack of communication from Sarah about what was going on, as she was known to be a private person, or that Sarah did not perceive herself to be at risk.

- (f) In addition to public services, friends, family members and employers are recognised as having a key role in identifying domestic abuse and supporting victims, as set out in the Government's Ending Violence Against Women and Girls Strategy:

“we need to make tackling violence against women and girls everybody's business. From health providers, to law enforcement, to employers and friends and family we all need to play our part.”⁷

- (g) A recommendation (3) is made for Basildon Community Safety Partnership to develop work with local employers to improve awareness and responses.
- (h) Changing Pathways have outlined the services they provide in the area that Sarah, her family, friends or colleagues could have accessed:
- (i) Refuge accommodation
 - (ii) Outreach support services
 - (iii) Independent Domestic Violence Advocates (hospital and community based)
 - (iv) Community and refuge based specialist support for children and young people
 - (v) Group based therapeutic interventions
 - (vi) Individual therapeutic / counselling services
 - (vii) Assistance with practical, emotional, physical and financial difficulties faced by those experiencing domestic abuse
- (i) Changing Pathways also deliver awareness raising and training sessions to partner agencies, in addition to inviting practitioners into their premises to break myths and misconceptions about domestic abuse survivors and the

⁷ https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/505961/VAWG_Strategy_2016-2020.pdf
[accessed 25 April 2016]

services available to support those whom are impacted. Two specialist consultants are commissioned to deliver a healthy relationships programme across primary and secondary schools in the areas in which the service operates.

- (j) Basildon Council and Community Safety Partnership also provided a list outlining the recent activities taken to raise awareness of domestic abuse in the area:
 - (i) 'Crucial Crew', run annually in the borough, taught young people about recognising the signs of healthy and unhealthy relationships and where any concerns can be reported (e.g. Changing Pathways, NSPCC, Childline).
 - (ii) A Domestic Abuse Awareness event was held in Basildon in November 2015 as part of Domestic Abuse Awareness Week to raise awareness of domestic violence and to promote the local services available. Community Safety Partnership representatives, local businesses, local councils, councillors and members of the public attended the event. The event showed the work of Changing Pathways, Victim Support and was supported by a speech from the Mayor and a local Reverend. A balloon release was also held to signify hidden harm. It was publicised in the local press and via social media.
 - (iii) Basildon Community Safety Partnership participated in the Stand Together Campaign to raise awareness of domestic abuse. This was an online campaign via social media, which encouraged agencies and the local community to 'tweet your feet' and join the conversation about domestic abuse. The partnership tweeted a photo and shared with social media and promoted the campaign using a press release and Essex Business and Leisure Magazine.
 - (iv) The Community Safety Partnership promoted the 'This is Abuse'⁸ website in October 2015 as part of their Borough Diary page, which is distributed to every household within the Basildon Borough. The article was used to raise awareness of what domestic abuse is and to encourage reporting and readers were signposted to the website.
- (k) From this list, Basildon Council has clearly prioritised the need to raise awareness of domestic abuse, and it is hoped that this work will continue.

⁸ An awareness site targeted at young people, now at: www.disrespectnobody.co.uk

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- (l) Did previous campaigns and awareness-raising from Changing Pathways and from Basildon Council/Community Safety Partnership outlined above ‘speak’ to Sarah? Had Sarah wanted to seek help about her relationship with Brendan, would she have thought that Changing Pathways was a service aimed at her? If she did not see herself as a ‘victim of domestic abuse/violence’ – and many people don’t – then she might not have connected with the campaigns, or sought their help.
- (m) The Southend, Essex and Thurrock Domestic Abuse Strategic Board (of which Basildon is a part) has recognised this as part of its ‘Together We Can’ awareness raising campaign. This was launched in early 2016, and has five parts. The second phase is aimed at raising awareness of domestic abuse and healthy relationships amongst young people.
- (n) The campaign has the following focus:
 - (i) Raising awareness in young people of the whole range of domestic abuse, encouraging and empowering them to have healthy, balanced relationships.
 - (ii) Raising awareness with family members and professionals who work with young people of the significance of a young person’s relationship.
 - (iii) Raising awareness with professionals across the range of domestic abuse services about the campaign, its goals and how they can better support young people.
- (o) The Strategy Board and Communications lead took the following steps to prepare and develop the campaign:
 - (i) Workshops with a group of professionals who work with victims and perpetrators of domestic abuse, and/or directly with young people.
 - (ii) A focus group of young people from the Young Essex Assembly to help understand issues, craft message and delivery.
 - (iii) Engagement with local community groups, charities and domestic abuse services.
 - (iv) Work with Risk Avert Healthy Relationships: a programme of healthy relationships education rolled out free to schools.
- (p) This campaign and the careful preparation are welcomed by this Review. The independent Chair has shared the learning from this case (anonymously) with the communications lead to ensure that these are incorporated even if this Review is not published before the campaign starts.

- (q) A recommendation has not been made in relation to awareness raising, in light of the work already ongoing by the Southend, Essex and Thurrock Domestic Abuse Strategic Board, that has directly worked with young people in the development of an Essex-wide awareness raising campaign.
- (r) A recommendation (4) is made for Changing Pathways to ensure that the information it provides about its services ‘speaks’ to young people, addressing the issues set out above. As Changing Pathways were part of the development of the Essex-wide campaign, they should already have a good insight into the ways in which to communicate with young people and therefore this knowledge should be applied to their own information provision – the wording, and where it is displayed.

4.2.2 *Early and effective responses to abusive behaviours exhibited by young men, including in relation to their mental health*

- (a) Brendan’s GP (Elmtree, November 2012), the College, Avon and Wiltshire Mental Health Partnership NHS Trust (October 2012) and CAMHS were aware of his relationship with his girlfriend (or a break-up), but each had different information:
 - (i) The College were aware of the impact a relationship was having on his studies
 - (ii) Elmtree GP knew that Brendan relied heavily on his girlfriend to support his mental health
 - (iii) Avon and Wiltshire Mental Health Partnership NHS Trust knew that it was a relationship ending that had caused him to take an overdose (and that his self-harm was less likely when he was in a relationship)
 - (iv) CAMHS were aware of abusive behaviours he had displayed towards an ex-girlfriend as well as the negative impact on his mental health of the ending of that relationship.
- (b) The DHR Panel discussed the possibility that Brendan’s young age masked his abusive behaviours, and that the professionals he was in contact with were perhaps not sufficiently aware of how young people can use abusive behaviours in intimate and family relationships. Nevertheless, they had sufficient information to see that Brendan was someone who placed significant importance on the maintenance of his intimate relationships, and this could have raised concerns.
- (c) None of these agencies responded to Brendan as an actual or potential domestic abuse perpetrator. Brendan’s college tutor stated that Brendan appeared to be acting as any young person would who was caught up in their

first real relationship. Avon and Wiltshire Trust assessed Brendan's risk to others as low. Brendan's GP records show that, despite his, and her, young age, Brendan's girlfriend was seen as a protective factor and accepted as his means of support. This is a significant burden to put on a young girl, and in light of the evidence referred to in this report, potentially increased the risk she faced from Brendan, as there was no recognition of the pressure placed on the relationship by Brendan and what the outcome could be if she tried to end it. This is particularly notable in light of the information from CAMHS that Brendan's mother had heard that he had attempted to strangle his girlfriend (although Brendan strongly denied this and his mother stated she did not believe it to be true).

- (d) CAMHS did not name Brendan's behaviours as abusive; Avon and Wiltshire Trust and Brendan's GP did not recognise the risk posed to Brendan's girlfriend in relation to his suicide threats/attempts; and the college did not appear to explore with Brendan the nature of his relationship in light of the fact that it was having an impact on his studies.
- (e) The risk factors that could have been identified by Brendan's GP, Avon and Wiltshire Trust and CAMHS were: Brendan's apparent dependence on his girlfriends; his self-harm and threats of suicide; and, for CAMHS, the smashing of his ex-girlfriend's laptop and alleged attempted strangulation.
- (f) The risk to victims of domestic violence/abuse from perpetrators who have threatened suicide is recognised in the Domestic Abuse, Honour Based Abuse, Stalking and Harassment (DASH) Risk Indicator Checklist⁹, which specifically asks whether the perpetrator has threatened suicide.
- (g) Research has shown that there are a number of risk factors that in some cases can be more significant than prior physical violence, including controlling behaviours, separation and threats of suicide¹⁰. This same research states: "*Campbell (2003) notes that suicide risk is significant when there is no history of physical abuse in the relationship.*"
- (h) If Brendan had been identified as a domestic abuse perpetrator it could have led to pathways of referral and risk assessment: for his (ex)girlfriend to be contacted and offered risk assessment and support to safety; and for Brendan to be referred to an appropriate perpetrator service or for his behaviours to be challenged by the mental health service with which he was engaging at

⁹ <http://www.dashriskchecklist.co.uk> [accessed 25 April 2016]

¹⁰ Regan, L., Kelly, L., Morris, A. and Dibb, R. (2007) *'If only we'd known': an exploratory study of seven intimate partner homicides in Engleshire* Final report to the Engleshire Domestic Violence Homicide Review Group, CWASU

the time. (It should be highlighted that local services are often not available, but nevertheless there are resources available and a national helpline through Respect¹¹). Research shows that when abusive behaviours are challenged in a safe and appropriate way, it can lead to behaviour change¹².

- (i) Sarah had no way of knowing about Brendan's previous behaviours¹³, and as he did not engage with any agency in Essex this information was not available to anyone. This would have impacted on her ability to risk assess her own situation.
- (j) The NHS England IMR states that NHS England will take action to improve awareness with GPs of the risk to partners when individuals threaten suicide, outlined above (see 4.4.9).
- (k) Recommendations (5 and 6) are made for New College and CAMHS to act on this learning.

4.2.3 *Early and effective responses to enduring mental health issues*

- (a) Sarah attended her GP on two occasions seeking help for her mental health; in the second attendance, there was no apparent reference to her previous episode. In addition there was a lack of follow up with Sarah when the referral to the Pathfinder service did not lead anywhere. Given that Sarah's mother has informed the Review that Sarah had self-harmed, this was a clear missed opportunity to support Sarah further with whatever difficulties she was experiencing.
- (b) Brendan attempted suicide, threatened suicide or talked about suicidal thoughts on four separate occasions (in addition to disclosing he had self-harmed a number of times). The first two (April 2011 and October 2012) were with the same General Practice (Elmtree); the next two were with different Practices (August 2014, White Horse Surgery and September 2014, Hawthorn). During these episodes, Brendan also had contact with three Police forces, two hospitals and three mental health trusts in relation to his mental health. As a result, it is possible that no one agency had all the information about his mental health. This could have been available to one of the General Practices, had the GP looked holistically at the history of Brendan's presentations to all services. It is not possible to ascertain from the

¹¹ <http://respect.uk.net>

¹² <https://www.dur.ac.uk/resources/criva/ProjectMirabalfinalreport.pdf> [accessed 25 April 2016]

¹³ Had she known of the Domestic Violence Disclosure Scheme ('Clare's Law'), she could have approached Police, but they would not have held information from mental health services. <https://www.gov.uk/guidance/domestic-violence-and-abuse#domestic-violence-disclosure-scheme>

records gathered for this review the extent to which any one professional knew of all the mental health interventions Brendan had accessed or been offered.

- (c) Brendan received an intensive intervention from CAMHS; the responses to his help seeking as an adult (albeit a young adult) relied on him to self-refer and to actively pursue support. After initial intensive responses were made to Brendan due to his high risk of suicide, interventions dropped off quickly to low level, community responses when the crisis had passed. A more intensive approach, recognising Brendan's young age, could have led to better outcomes for him, but this is not the way in which adult services work when there is not an apparent crisis.
- (d) Brendan consistently threatened suicide, and at two points attempted it, but was able to satisfy professionals, in part through his active help seeking, that he was not serious about killing himself. The DHR Panel discussed the fact that the nature of adult mental health services is to rely very much on the individual to proactively seek help, in contrast to the proactive response from CAMHS that Brendan had received. Brendan was technically an adult, but a young one, who appeared to have a recurring need for support and it was perhaps optimistic to expect him to always seek support for himself.
- (e) Due to Brendan moving between areas and services, it is probable that no one professional had all the information available, which has been gathered here for this Review. In particular, as he did not register with a General Practice (or access any other service) in Essex, this information was not available to any professional. If his final GP, Hawthorn, had all the information about Brendan's history in August and September 2014, they could have proactively reached out to Brendan to offer support; but we cannot know if they had the information, or whether they reviewed it, or whether Brendan would have accepted any support offered.
- (f) The complexity of mental health services, and the diversity of service provision and design, were notable in this case and is supported by the mental health expert from NHS England who contributed to the Review. Terms such as 'enduring mental illness' do not have common, agreed definitions between services and are little understood by those outside the system. The way in which 'primary mental health services' (usually for so-called lower level issues such as anxiety and depression) and 'secondary mental health services' (usually for diagnosable conditions such as schizophrenia, psychosis) are defined and managed differently in different areas.

- (g) The NHS website states: *“How people access services will depend on individual circumstances, such as their age, the specific problem, or how urgently care is required. This means that in addition to the different services, there are also different care pathways. ... depending on how services are arranged in a local area, you may find specific teams that only deal with one particular care pathway – for example, an eating disorders team. But there are also teams that address a variety of disorders in one common pathway, such as community care for anxiety and depression. Some pathways will work across teams and settings.”*¹⁴
- (h) This complexity and variety of care meant that Brendan moved between services without being identified as someone with ongoing issues, and these did not appear to be picked up by his GP. Had he been responded to more proactively and holistically, he may have been offered more intensive support; we cannot say whether he would have taken it up, or whether it would have impacted on the eventual outcome.

4.3 Recommendations

The recommendations below should be acted on through the development of an action plan, with progress reported on to the Basildon Community Safety Partnership within six months of the Review being approved by the Partnership.

4.3.1 Recommendation 1 (see 4.3.4)

Basildon and Brentwood Clinical Commissioning Group to engage with the new Sexual Health Services provider to ensure that they are following the good practice developed by NELFT that has been highlighted in this review; if it is not in place, for action to be taken to establish new processes. To also work with all commissioned providers of sexual health services to ensure that training from relevant experts supports routine enquiry and that enquiry is conducted in the most safe and appropriate way.

4.3.2 Recommendation 2 (see 4.2.5)

NHS England to share the findings from this Review, particularly drawing out the learning for General Practices, with those practices that were involved in the case.

4.3.3 Recommendation 3 (see 5.2.1.g)

¹⁴ <http://www.nhs.uk/NHSEngland/AboutNHSservices/mental-health-services-explained/Pages/services-explained.aspx> [accessed 22 September 2016]

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Basildon Community Safety Partnership to develop a project to work with local employers to improve awareness and responses to domestic abuse, including through workplace policies and training.

4.3.4 Recommendation 4 (see 5.2.1.r)

Changing Pathways to utilise the learning from this Review, and the knowledge gained through supporting the development of the Essex-wide awareness campaign to inform their own leaflets, posters and ways of advertising their service locally; to ensure that the information provided about its services ‘speaks’ to young people.

4.3.5 Recommendation 5 (see 4.7.7 and 5.2.2.i)

Oxford Health NHS Foundation Trust Child and Adolescent Mental Health Service to incorporate the development and implementation of safe and appropriate responses to young (potential) domestic abuse perpetrators within its service, with reference to the information provided by Respect¹⁵.

4.3.6 Recommendation 6 (see 4.11.6 and 5.2.2.i)

New College Swindon to use the learning from this Review to: carry out (or commission) training for staff to develop in depth understanding of domestic abuse and young people and ensure that they are able to provide safe and appropriate responses to suspected victims and perpetrators; and to ensure information is displayed and communicated to students about available support if they have concerns about their own relationship.

4.3.7 Recommendation 7 (see 4.11.2)

New College Swindon to use the learning from this Review to take action to ensure that information received by college lecturers and other academic (non-pastoral) staff about students being in contact with support services is recorded.

¹⁵ <http://respect.uk.net/work/respect-young-peoples-service/>

Appendix 1: Domestic Homicide Review

Terms of Reference

This Domestic Homicide Review is being completed to consider agency involvement with Sarah, and Brendan following her death. The Domestic Homicide Review is being conducted in accordance with Section 9(3) of the Domestic Violence Crime and Victims Act 2004.

Purpose

1. Domestic Homicide Reviews (DHR) place a statutory responsibility on organisations to share information. Information shared for the purpose of the DHR will remain confidential to the panel, until the panel agree what information should be shared in the final report when published.
2. To review the involvement of each individual agency, statutory and non-statutory, with Sarah and Brendan during the relevant period of time: 1 January 2006 – date of the homicide.
3. To summarise agency involvement prior to 1 January 2006.
4. The start date may change as further information becomes available about the victim and perpetrator.
5. To establish whether there are lessons to be learned from the case about the way in which local professionals and agencies work together to identify and respond to disclosures of domestic abuse.
6. To identify clearly what those lessons are, how they will be acted upon and what is expected to change as a result and as a consequence.
7. To improve inter-agency working and better safeguard adults experiencing domestic abuse and not to seek to apportion blame to individuals or agencies.
8. To commission a suitably experienced and independent person to:
 - a) chair the Domestic Homicide Review Panel;
 - b) co-ordinate the review process;
 - c) quality assure the approach and challenge agencies where necessary; and
 - d) produce the Overview Report and Executive Summary by critically analysing each agency involvement in the context of the established terms of reference.
9. To conduct the process as swiftly as possible, to comply with any disclosure requirements, panel deadlines and timely responses to queries.
10. On completion present the full report to the Basildon Community Safety Partnership.

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Membership

11. It is critical to the effectiveness of the meeting and the DHR that the correct management representatives attend the panel meetings. Your agency representative must have knowledge of the matter, the influence to obtain material efficiently and can comment on the analysis of evidence and recommendations that emerge.
12. The following agencies are to be on the Panel:
 - a) Basildon Borough Council
 - b) Changing Pathways (formerly Basildon Women's Aid)
 - c) Essex Police
 - d) NHS England
 - e) Basildon and Brentwood Clinical Commissioning Group
13. Further agencies may be asked to be part of the Panel if their involvement with the victim / perpetrator becomes apparent through the information received from the above agencies.
14. If the need for a representative from a specialist mental health service arises, the chair will liaise with and if appropriate ask them to join the panel.
15. There are no parallel reviews ongoing alongside this review, with the exception of the criminal investigation and trial.

Collating evidence

16. Each agency to search all their records outside the identified time periods to ensure no relevant information was omitted, and secure all relevant records.
17. Chronologies and IMRs will be completed by the following organisations known to have had contact with the victim or perpetrator:
 - a) General Practitioners for the victim and perpetrator (completed by NHS England)
 - b) West Midlands Police
 - c) Thames Valley Police
 - d) Durham Constabulary
18. Further agencies will be asked to completed chronologies and IMRs if their involvement with the victim / perpetrator becomes apparent through the information received from the above agencies.
19. Each agency must provide a chronology of their involvement with the Sarah and Brendan during the relevant time period.
20. Each agency is to prepare an Individual Management Review (IMR), which:
 - a) sets out the facts of their involvement with Sarah and/or Brendan;
 - b) critically analyses the service they provided in line with the specific terms of reference;
 - c) identifies any recommendations for practice or policy in relation to their agency, and
 - d) considers issues of agency activity in other boroughs and reviews the impact in this specific case.

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21. Agencies that have had no contact should attempt to develop an understanding of why this is the case and how procedures could be changed within the partnership which could have brought Sarah or Brendan in contact with their agency.

Analysis of findings

22. In order to critically analyse the incident and the agencies' responses to the family, this review should specifically consider the following six points:
 - a) Analyse the communication, procedures and discussions, which took place between agencies.
 - b) Analyse the co-operation between different agencies involved with the victim, perpetrator, and wider family.
 - c) Analyse the opportunity for agencies to identify and assess domestic abuse risk.
 - d) Analyse agency responses to any identification of domestic abuse issues.
 - e) Analyse organisations access to specialist domestic abuse agencies.
 - f) Analyse the training available to the agencies involved on domestic abuse issues.

Liaison with the victim's and perpetrator's family

23. Sensitively involve the family and friends/colleagues of Sarah in the review, once it is appropriate to do so in the context of on-going criminal proceedings. Also to explore the possibility of contact with any of the perpetrator's friends or family who may be able to add value to this process. The chair will lead on family engagement with the support of the Police Senior Investigating Officer and the Family Liaison Officer.
24. Co-ordinate family liaison to reduce the emotional hurt caused to the family by being contacted by a number of agencies and having to repeat information.

Development of an action plan

25. Individual agencies will take responsibility to establish clear action plans for agency implementation as a consequence of any recommendations in their IMRs. The Overview Report will make clear that agencies should report to the Community Safety Partnership on their action plans within six months of the Review being completed.
26. Community Safety Partnership to establish a multi-agency action plan as a consequence of the recommendations arising out of the Overview Report, for submission to the Home Office along with the Overview Report and Executive Summary.

Media handling

27. Any enquiries from the media and family should be forwarded to the chair who will liaise with the CSP. Panel members are asked not to comment if requested. The chair will make no comment apart from stating that a review is underway and will report in due course.
28. The CSP is responsible for the final publication of the report and for all feedback to staff, family members and the media.

Confidentiality

29. All information discussed is strictly confidential and must not be disclosed to third parties without the agreement of the responsible agency's representative. That is, no

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material that states or discusses activity relating to specific agencies can be disclosed without the prior consent of those agencies.

30. All agency representatives are personally responsible for the safe keeping of all documentation that they possess in relation to this DHR and for the secure retention and disposal of that information in a confidential manner.
31. It is recommended that all members of the Review Panel set up a secure email system, e.g. registering for criminal justice secure mail, nhs.net, gsi.gov.uk, pnn or GCSX. Confidential information must not be sent through any other email system. Documents can be password protected.

Disclosure

32. Disclosure of facts or sensitive information may be a concern for some agencies. We manage the review safely and appropriately so that problems do not arise and by not delaying the review process we achieve outcomes in a timely fashion, which can help to safeguard others.
33. The sharing of information by agencies in relation to their contact with the victim and/or the alleged perpetrator is guided by the following:
 - a) Human Rights Act: information shared for the purpose of preventing crime (domestic abuse and domestic homicide), improving public safety and protecting the rights or freedoms of others (domestic abuse victims).
 - b) Common Law Duty of Confidentiality outlines that where information is held in confidence, the consent of the individual should normally be sought prior to any information being disclosed, with the exception of the following relevant situations – where they can be demonstrated:
 - i) It is needed to prevent serious crime
 - ii) there is a public interest (e.g. prevention of crime, protection of vulnerable persons)

Appendix 2: Brendan’s contact with agencies, chronological

Agency	Contact
Thames Valley Police	<p>April 2011 (very early hours of the morning) Thames Valley Police received a call from a member of the public who reported concerns about a person with whom they were talking online (via an online game), who was subsequently identified as Brendan. Brendan had told the caller that he had recently split up with his partner, and that he was going to go out of the house and kill himself. Brendan told the caller that his mother was alive but that he did not speak to her. The caller continued to talk online to Brendan while speaking with Police, and tried to gain more details that would identify Brendan and enable a Police response. Brendan informed the caller that he was aged 17 years and lived a few miles from Swindon, following which Thames Valley Police were able to locate him. Due to Brendan’s location, Thames Valley Police contacted Wiltshire Police to attend the incident, as they were closer and would therefore get there faster. Thames Valley Police then attended and dealt with the incident alongside Wiltshire Police.</p>
Wiltshire Police	<p>Wiltshire Police officers attended the Brendan’s address following a request from Thames Valley Police, as outlined above. Officers spoke to a male who identified himself as Brendan. The attending officers recorded that Brendan looked “<i>sheepish</i>” and that the concern over his suicide had reduced. Brendan was recorded as having been taken voluntarily to an Avon and Wiltshire Mental Health NHS Partnership Trust inpatient unit. (The Trust has no record of an inpatient stay by Brendan, or a visit by him on that date.)</p>
General Practice (GP) Elmtree (Wiltshire)	<p>April 2011 Brendan attended Elmtree General Practice (Wiltshire) and was recorded as reporting “<i>low mood and suicidal ideation</i>”. The record stated that he had broken up with his girlfriend of three years and that the Police had been called due to his state of mind (see Thames Valley Police and Wiltshire Police above). Brendan was recorded as “<i>having plans</i>” and “<i>will do it [commit suicide] if left alone</i>”. The GP contacted the mental health crisis team to make an urgent referral (see CAMHS below)</p>

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Agency	Contact
Oxford Health NHS Foundation Trust: Child and Adult Mental Health Service (CAMHS)	April 2011 the CAMHS Consultant Clinical Psychologist met with Brendan and his mother, following an urgent referral from Brendan’s General Practice (see above). Brendan stated that he felt uncomfortable discussing everything with his mother present and so was seen alone. Brendan was recorded as feeling suicidal following the break-up of a relationship, and at risk of self-harm. A risk assessment and care plan was made and shared with Brendan and his mother. Brendan was offered support from the outreach service immediately, and an urgent psychiatric assessment was requested. Brendan’s mother reported that Brendan was booked to attend a camp, organised by his college as part of his course that would delay the assessment. Brendan’s mother agreed to discuss with Brendan and the camp organisers’ safety issues regarding Brendan going away when displaying high-risk behaviours. The team checked this, and a plan was put in place with Brendan and the staff running the camp.
Oxford Health NHS Foundation Trust: Child and Adult Mental Health Service (CAMHS)	A home visit was conducted by the outreach service, prior to Brendan leaving for the camp. An assessment of Brendan’s mental state was conducted. Brendan was recorded as appearing to be “ <i>low in mood</i> ”; with concentration, appetite and sleep noted as poor but with no current suicidal plans. Brendan reported having self-harmed for the last time around 18 months prior, and that he had sought help about this from his college counselling service. Techniques for managing his emotions were provided and discussed with Brendan. Brendan’s protective factors were listed as a good friendship group, being able to talk to his mother, and that he was making future plans about finishing college and joining the fire service.
Oxford Health NHS Foundation Trust: Child and Adult Mental Health Service (CAMHS)	A second home visit was made with Brendan and his mother the next day. Brendan reported that he had been upset after a phone call with his ex-girlfriend but had managed this by talking to a friend. The service also met with Brendan’s mother, and discussed arrangements regarding the upcoming trip. There were further discussions on distraction techniques for Brendan to use in managing his emotions. An appointment for the psychiatric assessment was booked for a couple of weeks later.
Oxford Health NHS Foundation Trust: Child and Adult Mental Health Service (CAMHS)	The service called Brendan to offer a home visit; Brendan declined as he was busy getting ready for the trip. Further telephone calls and texts were made from this point on to check on Brendan’s wellbeing while he was away and to offer support.

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Agency	Contact
Oxford Health NHS Foundation Trust: Child and Adult Mental Health Service (CAMHS)	The service called Brendan to find out how he was after the trip. Brendan reported that it had been good, a good distraction and had helped him to not think about his recently ended relationship, and that he had made friends. His mood had been low since the day before as his ex-girlfriend had changed her mobile phone number and removed him from her social media contacts, which meant he could no longer contact her. Brendan was recorded as being depressed and upset following the break up, and that any harmful behaviour he described was directed at himself.
Oxford Health NHS Foundation Trust: Child and Adult Mental Health Service (CAMHS)	The Consultant Psychiatrist conducted the psychiatric assessment. Brendan was recorded as not “ <i>pervasively</i> ” low in mood, but continued to have suicidal thoughts such as jumping in front of a train or jumping from a building. The main concerns were that he might act impulsively in a crisis. He stated that since he had returned from his trip, he had had contact with his ex-girlfriend during which he “ <i>smashed up her laptop</i> ”. He reported that he had found this “ <i>freed up a lot of angry feelings</i> ”. The assessment noted “ <i>interdependence issues</i> ” with the ex-girlfriend. Brendan and his mother were spoken with together, and also separately. When Brendan’s mother was spoken with alone, she disclosed that she had “heard [from a third party] that Brendan had tried to strangle [his ex-girlfriend] in the past” but that she did not think it was true. Brendan was asked about this, and he strongly denied any violence in the relationship. The assessment concluded that Brendan was experiencing an adjustment reaction to the end of the relationship, and that there was no enduring mental illness. Brendan stated that he was finding the outreach service to be supportive and helpful. As Brendan would shortly turn 18 years old, a possible (i.e. if required) referral to adult mental health services was discussed; Brendan was happy for this to happen. A discussion was held between the Consultant Psychiatrist and the outreach service to make plans for supporting Brendan through ongoing outreach. A risk plan was agreed relating to the risk identified: “impulse serious act of self harm not in the context of a mental illness”.
General Practice (GP) Elmtree (Wiltshire)	Elmtree recorded receipt of a letter from the Swindon Child and Adolescent Mental Health Service (CAMHS) that they had seen Brendan and their assessment was that he was “ <i>experiencing an adjustment reaction in the context of the ending of an intense relationship</i> ” and that the community team were continuing support.
Oxford Health NHS Foundation Trust: Child and Adult Mental Health Service (CAMHS)	A telephone call was made to arrange a home visit for the next day,. At that visit, Brendan was recorded as feeling low over the weekend, but following conversations with a friend’s mother, was feeling more positive. His sleep, appetite and energy were back to normal. A crisis plan was made in which Brendan would telephone the GP out of hours if he was feeling overwhelmed, in order to get CAMHS support if required; and to continue to talk to friends and family when possible.

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Agency	Contact
Oxford Health NHS Foundation Trust: Child and Adult Mental Health Service (CAMHS)	A further telephone call was made to Brendan, in which Brendan described feeling good. No concerns were noted.
Oxford Health NHS Foundation Trust: Child and Adult Mental Health Service (CAMHS)	Brendan's college called the service ; Brendan's "tutor" reported knowing Brendan well, described him as "popular and well liked", and stated that there were no problems. The "tutor" agreed to support Brendan with extending deadlines to help him to complete the course. This support was confirmed as helpful to Brendan's wellbeing in a letter from CAMHS to the college.
Oxford Health NHS Foundation Trust: Child and Adult Mental Health Service (CAMHS)	At a home visit, the service recorded that Brendan's "mood [was] much improved" and that he was making plans for returning to college. He reported being able to be in contact with his ex-girlfriend with no adverse feelings or reactions. Brendan continued to use the distress tolerance techniques to cope with his emotions, and planned to see the college counsellor when he returned.
Oxford Health NHS Foundation Trust: Child and Adult Mental Health Service (CAMHS)	A joint meeting of CAMHS and adult mental health services was held in May 2011, to evaluate whether Brendan needed to transition to adult services when he turned 18 shortly. It was agreed that Brendan would not transfer to adult services, rather that CAMHS would gradually withdraw support and discharge Brendan when he turned 18. This plan was made as Brendan was reporting feeling better, with no suicidal thoughts and feeling ok most of the time. When he didn't feel ok he felt upset or angry. It was noted that Brendan strongly denied any past violence to his ex-girlfriend. The service assessed that Brendan's "adjustment disorder [was] resolving" and there were no apparent risk factors. A note was included of "[s]ome dependence issues evident".
Oxford Health NHS Foundation Trust: Child and Adult Mental Health Service (CAMHS)	The service made a home visit, and continued positive improvement of Brendan's mood and behaviour were noted. This was confirmed during a telephone call a couple of weeks later.
Oxford Health NHS Foundation Trust: Child and Adult Mental Health Service (CAMHS)	The last visit to Brendan was made at the end of May 2011. Brendan was provided with information about adult mental health services in case he needed them in the future, and it was noted that he had no need for them at that time. Brendan was discharged from the service.

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Agency	Contact
Avon and Wiltshire Mental Health Partnership NHS Trust	Brendan saw the Mental Health Liaison Team in October 2012 after he had been admitted to the Great Western Hospital in Swindon following an overdose of 16 ibuprofen and 48 paracetamol. He received a full psychosocial assessment by the Mental Health Liaison practitioner, who recorded that it had been an impulsive overdose with no clear suicidal intent and Brendan had sought prompt help. The end of his relationship with his girlfriend had triggered the overdose. It was recorded that Brendan had self-harmed by cutting on two occasions when he was 14 years old, and also that he had stabbed himself after a relationship breakdown three years previously (i.e. aged 16). He was with his ex-girlfriend when he took the overdose and she called an ambulance within minutes. Brendan was adamant he would not do this again and was recorded as having given “plausible reasons as to why”. On assessment Brendan described his mood as happy and there was no evidence of low mood at that time. His sleep pattern was good as was his appetite; he was keeping active by training and cycling and had future orientated plans. There was no evidence of any abnormal perceptions or thought processes. Brendan did identify he had experienced thoughts of harming himself, but that these were less likely to occur when he was in a relationship. Brendan’s risk to himself or others was assessed as low. The assessment did not identify any enduring mental illness: the lack of a job, and a relationship break up, were recorded to have triggered the overdose. Brendan was advised to access counselling services through primary care and a Samaritans call was arranged for the following week. No indication for secondary mental health services was identified.
General Practice (GP) Elmtree (Wiltshire)	Later in October 2012 Elmtree recorded a notification of Brendan’s attendance at hospital for a deliberate overdose of paracetamol by Brendan (see Avon & Wiltshire Mental Health Partnership NHS Trust above).
General Practice (GP) Elmtree (Wiltshire)	In November 2012 Brendan had an appointment at Elmtree about his mental health. The following was recorded: “ <i>history of depression and deliberate self harm, most recently 1 month ago, admitted to hospital. Looking for work, low most days, girlfriend is ‘his rock’. Anxious about relationship breaking down. Thoughts of self harm 1-2 days a week but no plans at present. Girlfriend is protective factor.</i> ” The GP recorded an urgent referral for Brendan to the counsellor, and medication for Brendan for one week.
General Practice (GP) Elmtree (Wiltshire)	Brendan was seen by the same GP one week later at which Brendan was recorded as “ <i>brighter, things ok at home, looking for work</i> ”. Two further weeks of medication were prescribed and the GP noted Brendan would “ <i>rebook with counsellor</i> ”.

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Agency	Contact
General Practice (GP) Elmtree (Wiltshire)	Brendan saw the same GP again and was recorded as stating his mood was now stable, he had left home as his mum was arguing with her partner, and he no longer wanted to see the counsellor because his girlfriend was his main support. He reported no thoughts of self-harm or suicide. Brendan called the GP the next day and stated he no longer needed medication.
General Practice (GP) Elmtree (Wiltshire)	Brendan missed his next appointment to review his mood, and spoke to the GP on the telephone. Brendan was recorded as reporting his mood being “good” at present, and was advised to attend the General Practice again if his mood worsened.
West Midlands Police	West Midlands Police were called to a shopping centre in Solihull by security due to a “ <i>male in blue approaching shoppers</i> ” and that he looked like he was harassing people. The male was identified as Brendan, and when spoken with by officers he stated that he was “just trying to make people smile”. No offences were disclosed and the incident was classified as “anti-social behaviour / nuisance” and closed.
General Practice (GP) Meadowside Family Health Centre (West Midlands)	Brendan was registered with Meadowside Family Health Centre (West Midlands) from August 2013 to September 2014; the only record was a notification from Darlington Hospital that Brendan had attended the Emergency Department accompanied by Police. This was dated on their system in August 2013; Durham Constabulary records show that they accompanied Brendan to Darlington Hospital in August 2014 (see below).
General Practice (GP) Hawthorn Medical Centre (Wiltshire)	Brendan was recorded as registering with Hawthorn Medical Centre (Wiltshire) end of August 2013
General Practice (GP) Hawthorn Medical Centre (Wiltshire)	The next record for Hawthorn Medical Centre (Wiltshire) was December 2013: “ <i>records waiting to be sent. Removal to new HA [Health Authority]</i> ”.

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Agency	Contact
Durham Constabulary	<p>August 2014 Durham Constabulary were called to a hotel in Darlington. Brendan had met with a local 16-year-old female; after spending the night together in the hotel, the female had left the hotel around 11.45am. Following this Brendan wrote a suicide note stating he had had a fantastic night but intended to throw himself from the hotel window. Brendan then sat on the ledge outside the fourth floor room, resulting in Police being called. The incident lasted approximately two hours, at the end of which Brendan was persuaded to come back inside by police negotiators. Officers then took Brendan to Darlington Memorial Hospital for a mental health assessment (see Tees, Esk and Wear Valleys NHS Foundation Trust, below). Following the Crisis Team’s decision that there was no need for further intervention, Brendan was arrested and charged with causing a public nuisance and bailed to attend court. The CPS later discontinued the case (see the contact made to Brendan’s GP Hawthorn by the Public Defender Service, below). The officer in the case submitted an adult concern referral for Brendan that was sent to and discussed with Adult Social Care Services. Following discussion the referral was not progressed, as no mental health issues had been identified. Brendan had not given his consent to the referral and so no additional support or information could be provided to him. A Children’s Social Care referral was made in relation to the 16-year-old female.</p>
Tees, Esk and Wear Valleys NHS Foundation Trust	<p>The Mental Health Liaison Team assessed Brendan after he had been brought to Darlington Hospital by Durham Constabulary (see above). Brendan was assessed to have ongoing issues with anxiety and social discomforts but not to be acutely mentally unwell. It was noted that Brendan had attempted to secure his own rescue by telling a third party what he was doing (this was the girl he had travelled to see). Following the assessment Brendan was discharged. Brendan agreed to gain future help in the area he lived (Swindon), including to register with a GP. Brendan was given literature about support services in case his mental health deteriorated. A Multi-Agency Safeguarding Hub (Children’s Safeguarding) referral was made for the 16-year-old female Brendan had travelled to Darlington to see.</p>
Tees, Esk and Wear Valleys NHS Foundation Trust	<p>One week later the Team made a follow up phone call to Brendan, and it was recorded that Brendan said he had registered with a GP (see White Horse surgery below) and was waiting for a call from a therapist the next day. Information on the assessment completed with Brendan, was recorded as having been sent to the GP (recorded by Meadowside GP with the date 2013, see above).</p>
General Practice (GP) White Horse Surgery (Oxfordshire)	<p>Brendan’s attended White Horse Surgery (Oxfordshire), and asked for counselling due to “<i>low mood</i>”. Brendan was provided with the details of the counselling service Talking Space and Brendan was recorded as saying he would self-refer.</p>

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Agency	Contact
General Practice (GP) White Horse Surgery (Oxfordshire)	The next day Brendan spoke with the same GP, having contacted Talking Space but still with concerns over his mental health. The record stated that he was coping and “ <i>sounded OK</i> ”. The GP called Talking Space who reported that Brendan had been feeling suicidal a few days ago and had planned to jump from a bridge but hadn’t done it. Brendan had reported two previous suicide attempts. He stated he was trying to get his job back and trying to help himself. The GP recorded that Talking Space had stated they would notify the General Practice as to whether they were going to organise psychiatric help. There were no further records in relation to this.
General Practice (GP) Hawthorn Medical Centre (Wiltshire)	September 2014 Brendan was again recorded as newly registered at Hawthorn Medical Centre (see above), and a FAST alcohol screen questionnaire was added to the system in which no concerns regarding Brendan’s alcohol consumption was recorded.
General Practice (GP) Hawthorn Medical Centre (Wiltshire)	September 2014 Brendan attended Hawthorn GP. Depression dating back to Brendan being 14 years old was noted, along with current thoughts of “ <i>jumping under a train or stabbing himself in the head</i> ”. It was recorded that Brendan resisted these thoughts, and was requesting psychological support. The GP referred him to the Primary Care Liaison Team (see Avon & Wiltshire Mental Health Partnership NHS Trust, 3.11) on the basis of Brendan’s high risk of suicide. The service spoke to Brendan while he was with the GP, and it was agreed that Brendan would contact the LIFT psychology service via the General Practice. (NB: the LIFT Psychology Service were contacted as part of this Review; they could find no record of Brendan accessing their service.)
Avon and Wiltshire Mental Health Partnership NHS Trust	September 2014 the Trust’s Primary Care Liaison Service (PCLS) received a referral from Brendan’s GP (White Horse Surgery, see above) for assessment. The Duty Nurse contacted Brendan the same day. Brendan was recorded as telling the Nurse that he was OK at the moment, and that he had just got off the phone from a job interview, which he was hoping to get. He informed the Nurse that if he could get a job then he would be fine, and did not need any medical input, just psychological. The Duty Nurse advised Brendan to contact the LIFT Psychology Services. (NB this service was contacted as part of the Review and they had no record of Brendan contacting them.) Brendan later called the Nurse back to confirm that he had booked an appointment with IAPT (Improving Access to Psychological Therapies). It was agreed that if he needed help before that, he could contact the service again, and if the intervention from IAPT was not helpful in addressing “his past trauma” he could contact his GP who could refer him to PCLS again. Brendan was then discharged from the service.

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Agency	Contact
General Practice (GP) Hawthorn Medical Centre (Wiltshire)	October 2014 Hawthorn recorded that Brendan had not attended his counselling session. On contacting him, Brendan stated that he had forgotten the appointment; a new one was made which he later cancelled. This was Brendan's last recorded contact with this or any GP.
General Practice (GP) Hawthorn Medical Centre (Wiltshire)	In October 2014 Hawthorn were contacted by the Public Defender Service, which requested a medical report and all medical notes for Brendan following an incident in which he had tried to jump from a building (see Durham Constabulary, above). They also asked the GP to give an opinion as to whether pursuing a prosecution would be in the public interest. A letter was sent, and the GP gave their opinion that it would not be in the public interest to prosecute Brendan.

Appendix 3: Action Plan

	Recommendation	Scope of Recommendation	Lead Agency	Key Milestones achieved in enacting recommendation	Target Date	Completion Date and Outcome
1.	<p>Basildon and Brentwood Clinical Commissioning Group (CCG) to engage with the new Sexual Health Services provider to ensure that they are following the good practice developed by NELFT that has been highlighted in this review; if it is not in place, for action to be taken to establish new processes.</p> <p>To also work with all commissioned providers of sexual health services to ensure that training from relevant experts supports routine enquiry is conducted in the most safe and appropriate way.</p>	Local	Basildon and Brentwood CCG	<ul style="list-style-type: none"> • Ensure engagement with the new Sexual Health Service provider • Work with all commissioned providers of sexual health services 	Feb-17	<p>PROVIDE have shared their Domestic Abuse Policy, Domestic abuse level 3 training PowerPoint slides and their level 2 Safeguarding training slides. These have been reviewed by Basildon and Brentwood CCG and the policy and level 3 training clearly describes that there should be a holistic assessment of patients and routine enquiries for domestic abuse - copies available for viewing.</p> <p>- PROVIDE have given assurances by “We are currently planning as to how we as a Lead Provider consolidate the variation between training levels for all mandatory training across the partnership to be assured of consistency, however we are assured of quality of training across the partnership”. The CCG will monitor this through</p>

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	Recommendation	Scope of Recommendation	Lead Agency	Key Milestones achieved in enacting recommendation	Target Date	Completion Date and Outcome
						<p>the contract monitoring meeting managed through ECC.</p> <p>- PROVIDE have reviewed their IT health care record systems and have identified that they are not assured in the nature of collecting information of the routine screen of potential Domestic abuse for their patients. Therefore they have requested an update of the system to explicitly capture the question “do you feel safe at home”. There is no timeline for completion and the service manager is escalating.</p> <p>- PROVIDE have also been put in contact with the Midwifery Head of Nursing at Basildon & Thurrock University Hospitals to explore how the Hospital captures the domestic abuse screening questions as it is routine practice within maternity services in the BTUH and shared learning maybe beneficial.</p>

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	Recommendation	Scope of Recommendation	Lead Agency	Key Milestones achieved in enacting recommendation	Target Date	Completion Date and Outcome
						<p>- BBCCG quality team are undertaking a quality assurance visit of the Sexual Health Clinic based at Basildon Hospital on 20.02.17. The provider of this service is PROVIDE based in Colchester. A key line of enquiry for the visit will be to gain assurance in terms of routine questions exploring potential domestic abuse situations.</p> <p>- BBCCG have requested an invite to the Sexual Health contract meetings held by Essex County Council, with a view to gain assurances on domestic abuse screening by the service provided by PROVIDE.</p> <p><i>ACTION COMPLETE.</i></p>
2.	NHS England to share the findings from this Review, particularly drawing out the learning for General Practices (GP), with the Practices that were involved in the case.	Regional	NHS England	<ul style="list-style-type: none"> To spread the learning from this incident to General Practices to try to improve the awareness of GPs in relation to risk of harm to others, particularly 	End of April 2017	<p>Easter bulletin was circulated to CCGs and all GP practices in the East DCO area – all of Essex, Cambs, Peterborough, Norfolk and Suffolk. Copy provided as evidence.</p> <p>Action complete.</p>

	Recommendation	Scope of Recommendation	Lead Agency	Key Milestones achieved in enacting recommendation	Target Date	Completion Date and Outcome
				<p>in relation to intimate relationships and the risk factors for violence in a relationship. To spread the learning from this incident to General Practices to increase recognition that reported violence in an under-18 relationship should be considered within a child safeguarding framework.</p> <ul style="list-style-type: none"> To share this learning through: incorporating the learning points into the quarterly Quality and Safety Learning Bulletin that is distributed to all General Practices in the Eastern Region; and through the local and national named GP/Primary Care Professional forum. 		

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	Recommendation	Scope of Recommendation	Lead Agency	Key Milestones achieved in enacting recommendation	Target Date	Completion Date and Outcome
3.	Basildon Community Safety Partnership (CSP) to develop a project to work with local employers to improve awareness and responses to domestic abuse, including through workplace policies and training.	Local	Basildon CSP	<ul style="list-style-type: none"> Attendance at the Basildon Business Group to give a presentation on the work of the CSP Hidden Harm Local Delivery Group. Engagement from local businesses to help improve awareness and responses to Domestic Abuse. 	31 st March 2018	<p>The Hidden Harm Local Delivery Group Lead attended the Basildon Business Group meeting in June 2017. Work has been undertaken by the group to develop a 'template' policy that could be utilised by local businesses to develop their own Domestic Abuse Policy.</p> <p>Presentation to the group included information on how businesses can improve their response to Domestic Abuse for their employees.</p> <p>Ongoing work will take place to engage businesses and support them</p> <p><i>ACTION COMPLETE.</i></p>
4.	Changing Pathways to utilise the learning from this Review, and the knowledge gained through supporting the development of the Essex-wide awareness campaign to inform their own leaflets, posters and ways of advertising their service	Local	Changing Pathways	<ul style="list-style-type: none"> Involvement in the 'Together We Can' awareness campaign Review CP leaflets and website with young victims of domestic abuse as part of Service User 	November 2016 SU Involvement Strategy for 2017	<p>CP service user 'story' use in the campaign.</p> <p><i>ACTION COMPLETE.</i></p>

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	Recommendation	Scope of Recommendation	Lead Agency	Key Milestones achieved in enacting recommendation	Target Date	Completion Date and Outcome
	locally; to ensure that the information provided about services ‘speaks’ to young people.			Involvement Plan to ensure they ‘speak’ to young people		
5.	Oxford Health NHS Foundation Trust Child and Adolescent Health Service to incorporate the development and implementation of safe and appropriate responses to young (potential) domestic abuse perpetrators within its service, with reference to the information provided by Respect.	Local	Oxford Health NHS Foundation Trust Child and Adolescent Health Service	<ul style="list-style-type: none"> Ensure that CAMHS staff consider the risks of domestic abuse to their clients and also those people associated with their clients. Domestic abuse training for CAMHS staff has been highlighted in this Domestic Homicide Review and will form part of the Safeguarding Children Work Plan for 2015/16. 		<p>The Head of Service is confident we have addressed the learning identified for CAMHS teams in Swindon, Wiltshire and BaNES relating to domestic abuse by delivering training to staff using a workshop style in Nov and Dec 2016. I have attached the lesson plan used for the workshops to show what was covered. The training we undertook lasted 3 hours including using case studies and time to practice the use of risk assessments. The workshops were open to all CAMHS practitioners and were well attended with positive evaluation. Additional sessions have also been subsequently offered for new staff and for those that had missed the original training.</p> <p><i>ACTION COMPLETE.</i></p>

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	Recommendation	Scope of Recommendation	Lead Agency	Key Milestones achieved in enacting recommendation	Target Date	Completion Date and Outcome
6.	New College Swindon to use the learning from this Review to: carry out (or commission) training for staff to develop in depth understanding of domestic abuse and young people and ensure that they are able to provide safe and appropriate responses to suspected victims and perpetrators; and to ensure information is displayed and communicated to students about available support if they have concerns about their own relationship.	Local	New College Swindon	<ul style="list-style-type: none"> Workshops delivered by Swindon Women’s Aid – more planned for summer 2017 Domestic Abuse (including within Teenage relationships) has been included in mandatory safeguarding training for all staff (in Induction and refresher /update training). 	Completed July 2017 Completed	<ul style="list-style-type: none"> Greater awareness from all staff around Domestic Abuse with a strong focus on relationship / teenage domestic abuse. <p><i>ACTION COMPLETE.</i></p>
7.	New College Swindon to use the learning from this Review to take action to ensure that information received by college lecturers and other academic (non-pastoral) staff about students being in contact with support services is recorded.	Local	New College Swindon	<ul style="list-style-type: none"> Personal Tutor system in place throughout college. All tutors are safeguarding trained and pilot underway with 3 tutors on college safeguarding team. The new Personal Tutor role has its focus knowing students well and supporting them. They refer into the 	Completed	<ul style="list-style-type: none"> Greater communication between students, colleagues and safeguarding to ensure early alerts on students for whom there is a concern More sophisticated reporting Multiple methods of reporting concerns (telephone, email, college systems and face to face) and high levels of

	Recommendation	Scope of Recommendation	Lead Agency	Key Milestones achieved in enacting recommendation	Target Date	Completion Date and Outcome
				<p>safeguarding team where there are concerns.</p> <ul style="list-style-type: none"> • Confidential Safeguarding Referral system available to all staff through college wide pastoral system • New recording system being developed for logging and reporting on safeguarding concerns. • Initial training and referral processes for safeguarding concerns included in staff induction. • Posters on what and how to report concerns well distributed throughout the college. 	<p>Completed</p> <p>Completed</p> <p>Completed</p>	<p>awareness regarding to whom concerns should be reported.</p> <p><i>ACTION COMPLETE.</i></p>

Appendix 4: Home Office Quality Assurance Panel Response



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Kayleigh Hopcroft
Housing and Community Services
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26 September 2017

Dear Ms Hopcroft,

Thank you for submitting the Domestic Homicide Review report for Basildon to the Home Office Quality Assurance (QA) Panel. The report was considered at the QA Panel meeting on 25 July 2017. I very much regret the delay in providing the Panel's feedback.

The QA Panel would like to thank you for conducting this review and for providing them with the final report. The Panel concluded this was a good review which has done well to draw out useful lessons despite the limited agency contact and the reluctance of family (although the mother subsequently met the chair and was kept updated), friends and the victim's employer to participate in the process. The Panel particularly commended the chair for the considerable work in gathering information from a number of agencies outside the Community Safety Partnership area.

There were, however, some aspects of the report which the Panel felt may benefit from further analysis, or be revised, which you will wish to consider:

- The action plan will need to be updated before publication as it contains completion dates that have passed;
- You may wish to note that the statutory guidance recommends a separate, standalone executive summary that can be read in isolation;



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- Please consider enhancing anonymity by removing identifying dates in the report, particularly in the chronology at appendix 2, and note that the perpetrator's initials are identified on page 67.

The Panel does not need to review another version of the report, but I would be grateful if you could include our letter as an appendix to the report. I would be grateful if you could email us at DHREnquiries@homeoffice.gsi.gov.uk and provide us with the URL to the report when it is published.

The QA Panel felt it would be helpful to routinely sight Police and Crime Commissioners on DHRs in their local area. I am, accordingly, copying this letter to your PCC for information.

Yours sincerely

Christian Papaleontiou
Chair of the Home Office DHR Quality Assurance Panel