DOMESTIC HOMICIDE REVIEW

London Borough of Haringey Safer Communities Partnership

Report into the murder of Jayne December 2016

Author: Davina James-Hanman OBE

August 2018

‘I can do no better than to repeat the words of her sister…who describes her as ‘an integral part of our family, a truly beautiful, gentle, wonderful, loving, fun, youthful, generous, loyal person – the life and soul of our family unit…. According to one of her daughters she was the happiest she had ever seen her at the time that you murdered her.’

HHJ Marks, sentencing remarks at the trial of Isaac

Glossary

AAFDA: Advocacy After Fatal Domestic Abuse
BEHMHT: Barnet Enfield & Haringey Mental Health Trust
BTP: British Transport Police
CCG: Clinical Commissioning Group
CMHT: Community Mental Health Team
CPA: Care Programme Approach
CPS: Crown Prosecution Service
CSP: Community Safety Partnership
DHR: Domestic Homicide Review
IDVA: Independent Domestic Violence Adviser
IMR: Individual Management Review
IRIS: Identification and Referral to Increase Safety
LB: London Borough
MARAC: Multi-Agency Risk Assessment Conference
MAPPA: Multi-Agency Public Protection Arrangements

Contents

DHR OVERVIEW REPORT INTO THE MURDER OF JAYNE, DECEMBER 2016

Preface

The Independent Chair and the DHR Panel members offer their deepest sympathy to all who have been affected by the death of Jayne[1], and thank them, together with the others who have contributed to the deliberations of the Review, for their participation, generosity of spirit and patience. It is clear that Jayne is much missed and that her loss has had a devastating impact on her family. Their involvement in this process has come at a significant personal cost to them and the Panel is profoundly grateful for their participation.

The Review Chair thanks the Panel for the professional manner in which they have conducted the Review and the Individual Management Review authors for their thoroughness, honesty and transparency in reviewing the conduct of their individual agencies.

The Panel enquired about the well-being of the train driver and off-duty police officer who witnessed the suicide attempt and were assured they were being supported and recovering well. We hope that continues to be the case.

1. Introduction

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

(a) A person to whom she was related or with whom she was or had been in an intimate personal relationship or

(b) A member of the same household as herself;

with a view to identifying the lessons to be learnt from the death.

Throughout the report the term 'domestic abuse' is used interchangeably with 'domestic violence', and the report uses the cross-Government definition as issued in March 2013. This can be found in full at Appendix B.

1.2 The purpose of a DHR is to:

- Establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims.

- Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result.

[1] Not her real name

- Apply these lessons to service responses including changes to policies and procedures as appropriate; and identify what needs to change in order to reduce the risk of such tragedies happening in the future to prevent domestic homicide and improve service responses for all domestic violence victims and their children through improved intra- and inter-agency working.

1.3. This Domestic Homicide Review (DHR) examines the circumstances leading up to the death of Jayne who was murdered in December 2016 by her friend and one-time partner, Isaac.

The decision to undertake a DHR was made by Haringey Community Safety Partnership in January 2017 in consultation with local specialists. The Home Office was duly informed. An independent Chair was appointed in April 2017 and the Panel met for the first time in May where IMRs were commissioned and agencies advised to implement any early learning without delay. In consultation with the Senior Investigating Officer, it was decided to delay some aspects of the DHR, such as meeting with family members, until the criminal investigation had concluded. Three further meetings of the Panel were subsequently held in June, July and May. The long gap between the third and fourth meeting was to allow for the criminal trial (including sentencing appeal) to conclude which did not occur until March 2018 and to include family members of the victim within the process.

1.4. Domestic violence is a key priority for Haringey Community Safety Partnership and is included in the Strategic Plan with an overarching aim of breaking '*the cycle of domestic and gender based violence by working in partnership to promote healthy and safe relationships'* by delivering the following outcomes:

- 75% of victims will experience a reduction in their risk levels through the IDVA and MARAC approaches over four years
- A reduction in the number of repeat referrals to the MARAC from 7% to 2% over four years
- Improved performance management

1.5. Domestic violence is also a priority for LB Haringey and they commission a number of specialist domestic abuse services. This includes Hearthstone (Haringey Domestic Violence Advice and Support Centre) which provides emotional and practical support for anyone experiencing domestic abuse in Haringey, including legal advice, housing advice, access to refuge accommodation, access to counselling and safety planning. Solace Women's Aid also run a range of services in Haringey, including a phone line for immediate advice, counselling and floating support. Solace also run North London Rape Crisis Service, which is for women and girls over the age of 14 who have experienced any form of sexual violence at any time in their lives. The Nia Project provides the local IDVA service for high risk victims and the Advocate-Educator for the IRIS Project which aims to improve responses to domestic abuse from Primary Care providers. Finally, the Domestic Violence Intervention Programme (DVIP) run services for women who have experienced domestic violence and services for men who have been violent to their partner to learn how to end their abusive behaviour.

2. Overview

Persons involved in this DHR

Name	Gender	Age at the time of the murder	Relationship with victim	Ethnicity
Jayne	F	51	Victim	Black British
Isaac[2]	M	64	Partner and perpetrator	Jamaican

Jayne had four children who were all adults at the time of her death.

2.1. Summary of the incident

2.1.1. In the afternoon of a December day in 2016, British Transport Police (BTP) received a call to attend Cheshunt train station, where there were reports that a male had jumped under a train. BTP officers attended and dealt with the incident. The injured male – Isaac[3] - was taken to the Royal London Hospital (RLH) by Air Ambulance. His injuries were not life threatening but they were life changing. Isaac's right arm was severed during the incident and his left arm was so injured that it subsequently had to be amputated above the wrist. As a consequence he stayed in the Royal London Hospital for the best part of a month.

2.1.2. Officers at the scene recovered a car key and subsequently identified Isaac's car parked in the station car park. From this, they were able to identify Isaac's home address which officers went to in an attempt to identify a next of kin. Entry was gained using the keys recovered from Cheshunt Station. Inside they found the apparently lifeless body of a woman along with signs of violence. An ambulance was called and the Metropolitan Police were notified. An attending paramedic pronounced life extinct at just before 8pm. The woman was identified as Jayne who lived in separate accommodation in a neighbouring local authority. A post-mortem examination established her cause of death to be neck compression by strangulation with a ligature and blunt force trauma to the head.

2.1.3. On 19th January 2017, Isaac was released from hospital into police custody. He gave a no comment interview but was still charged with murder.

2.1.4. The trial had been scheduled to take place on Tuesday 2nd January 2018 and indeed began to get underway with jury selection. Isaac then interrupted proceedings and asked to speak to his barrister which resulted in a change of plea from guilty to manslaughter on the grounds of diminished responsibility to guilty of murder. He was duly convicted and was sentenced to life imprisonment with a recommendation he serve at least 26 years.

2.1.5. In March 2018, the Court of Appeal heard an application by the Solicitor General regarding the sentencing of Isaac. The Solicitor General appealed the sentence on the basis it was unduly lenient. The Court of Appeal agreed and Isaac's minimum term of imprisonment was increased to 30 years.

[2] Not his real name

3. Parallel reviews

3.1. An inquest was opened by Her Majesty's Coroner, and was adjourned pending the outcome of the criminal trial. Communication channels were established with the Coroner who at the time of writing this report is deciding whether to re-open the inquest. To aid in this process, it was agreed that a confidential copy of this report will be provided prior to Home Office approval.

3.2. Isaac had been under the care and supervision of mental health services since 1993 when he was convicted of unlawfully killing a second partner. As a consequence, Camden and Islington NHS Foundation Trust undertook a level 2[4] Serious Incident Investigation which completed in June 2017. This is discussed later in the report.

4. Domestic Homicide Review Panel

The DHR Panel was comprised of the following:

Davina James-Hanman, Independent DHR Chair and report author
Angela Middleton, NHS England
Christine Dyson, Interim designated nurse for safeguarding adults, Islington CCG
Dave Fearon, Senior Service Manager, Camden and Islington NHS Foundation
Des Fahy, Haringey Borough Commander, Metropolitan Police
DS Allison Hamer, Specialist Crime Review Group, Metropolitan Police
Fiona Dwyer, Strategic Violence Against Women and Girls Lead, LB Haringey
Hazel Ashworth, Designated Professional for Safeguarding Adults NHS Haringey Clinical Commissioning Group (CCG)
Jasper South, Head of Tenancy Services, LB Haringey
Joe Benmore, Offender Management Strategic Lead, LB Haringey
Karen Ingala Smith, CEO, Nia
Manju Lukhman, VAWG Strategy and Commissioning Manger, LB Islington
Sharmeen Narayan, Senior Manager, Solace Women's Aid
Shruthi Belavadi, Clinical Quality Manager (Patient Safety) North Central & East London

5. Independence

The author of this report, Davina James-Hanman, is independent of all agencies involved and had no prior contact with any family members. She is an experienced DHR Chair and is also nationally recognised as an expert in domestic violence having been active in this area of work for over three decades. Further details are provided in appendix C.

All Panel members and IMR authors were independent of any direct contact with the subjects of this DHR and nor were they the immediate line managers of anyone who had had direct contact.

6. Terms of Reference and Scope

6.1. The full terms of reference can be found at appendix A. The key lines of inquiry were as follows:

1. Each agency's involvement with the victim January 2014 to December 2016.

[4] A level 2 investigation means that the review was undertaken by an independent Chair

2. Each agency's involvement with the perpetrator from 1993 onwards.

3. Whether, in relation to either Jayne or Isaac, an improvement in communication between services might have led to a different outcome for Jayne.

4. Whether the work undertaken by services in this case was consistent with each organisation's professional standards.

5. Whether the work undertaken by services in this case was consistent with each organisation's domestic violence policy, procedures and protocols.

6. The response of the relevant agencies to any referrals relating to Jayne, concerning domestic violence, stalking and harassment or other significant harm from Isaac. It will seek to understand what decisions were taken and what actions were carried out, or not, and establish the reasons. In particular, the following areas will be explored:

(a) Identification of the key opportunities for assessment, decision making and effective intervention in this case from the point of any first contact onwards.

(b) Whether any actions taken were in accordance with assessments and decisions made and whether those interventions were timely and effective.

(c) Whether appropriate services were offered/provided and/or relevant enquiries made in the light of any assessments made

(d) The quality of the risk assessments undertaken by each agency in respect of Jayne and Isaac.

7. The response of the relevant agencies to any referrals relating to Isaac, concerning any other behaviour (including domestic violence, stalking and harassment or other significant harm) from Isaac to any other women. It will seek to understand what decisions were taken and what actions were carried out, or not, and establish the reasons. In particular, the following areas will be explored:

(a) Identification of the key opportunities for assessment, decision making and effective intervention in this case from the point of any first contact onwards.

(b) Whether any actions taken were in accordance with assessments and decisions made and whether those interventions were timely and effective.

(c) Whether appropriate services were offered/provided and/or relevant enquiries made in the light of any assessments made

(d) The quality of the risk assessments undertaken by each agency in respect of other women and Isaac.

8. The quality and quantity of training provided by services to their staff to enable effective implementation of responses.

9. Whether thresholds for intervention were appropriately calibrated, and applied correctly, in this case.

10. Whether practices by all agencies were sensitive to the ethnic, cultural, linguistic and religious identity of the respective family members and whether any special needs on the part of either adult were explored, shared appropriately and recorded.

11. Whether issues were escalated to senior management or other organisations and professionals, if appropriate, and in a timely manner.

12. Whether the impact of organisational change over the period covered by the review had been communicated well enough between partners and whether that impacted in any way on partnership agencies' ability to respond effectively.

13. Were there any concerns amongst family / friends / colleagues or within the community and if so how could such concerns have been harnessed to enable intervention and support?

6.2. Agencies were asked to search their records from 2014 for Jayne and from 1993 for Isaac which is when he was convicted of an unlawful killing for the second time. The Panel decided not to review in detail the circumstances of the first killing in 1981 as it was felt there would be limited lessons to be learned from agency responses at that time.

6.3. A number of questions were posed by Jayne's family which the Panel also sought to answer. These focused principally on the management of Isaac and the additional information these questions generated has been integrated into this report. The Panel are not only grateful for their willingness to engage but also for their forensic attention to detail.

7. Confidentiality and dissemination

7.1. The findings of this Overview Report are restricted. Information is available only to participating officers/professionals and their line managers, until after the Review has been approved for publication by the Home Office Quality Assurance Panel. Members of the victim's family have also been provided with a copy of the report.

7.2 As recommended within the 'Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews' to protect the identities of those involved, pseudonyms have been used and precise dates obscured.

7.3 The Executive Summary of this report has also been anonymised.

7.4 This has not prevented agencies taking action on the findings of this Review in advance of publication.

7.5 Subsequent to permission being granted by the Home Office to publish, this report will be widely disseminated including, but not limited to:

- Members of the Haringey Community Safety Partnership
- The Coroner
- Members of the Violence Against Women Working Group

7.6 A number of learning events have been planned to ensure that the lessons are disseminated as widely as possible; the first of these will be a confidential briefing to key local partners which will share the critical learning from this DHR. Once permission is granted by the Home Office to publish, this report will be more widely disseminated to the local professional network including Community Safety Partnership, VAWG Strategic Group and VAWG Advisory Group. Learning will be further incorporated into the VAWG Training

Standards. All DHRs are published on a permanent hyperlink on Haringey's website - www.haringey.gov.uk/dhr.

8. Methodology

8.1. The agencies listed below submitted an IMR:

- Islington CCG
- Camden & Islington NHS Foundation Trust[5]

8.1.1. Barnet, Enfield and Haringey Mental Health Trust provided extensive information relating to Isaac's time under their care. A full IMR was not completed but at the request of the Panel, they focused on answering the questions from the family.

8.1.2. Chronologies were provided by Jayne's GP and the Metropolitan Police. In each instance, the Panel scrutinised these and asked further clarification questions. As contact was minimal, it was felt that a full IMR was not required although information from each appears in this report.

8.1.3. The National Probation Service provided written information regarding what would happen to the perpetrator should a similar set of circumstances occur now.

8.1.4. A further 8 agencies advised they had not had any contact with either Jayne or Isaac.

8.2. Agencies completing IMRs and reports were asked to provide chronological accounts of their contact with Jayne and/or Isaac prior to the homicide. The recommendations to address lessons learnt are listed in section 13 of this report and action plans to implement those recommendations are included in Appendices D and E.

8.2.1. The Review Panel has checked that the key agencies taking part in this Review have domestic violence policies and is satisfied that where these exist, they are fit for purpose.

8.2.2. The Panel and Individual Management Review (IMR) Authors have been committed, within the spirit of the Equalities Act 2010, to an ethos of fairness, equality, openness, and transparency, and have ensured that the Review has been conducted in line with the terms of reference.

8.3. This report is an anthology of information and facts gathered from:

- The Individual Management Reviews (IMRs) and short reports
- The Police Senior Investigating Officer
- The criminal trial and associated press articles
- DHR Panel discussions
- Information from family members.

8.3.1. Haringey Community Safety Partnership is responsible for monitoring the implementation of the action plans (appendices D and E).

8.4. In preparation for the criminal trial, the Metropolitan Police took a number of statements from witnesses and family members. Each person was contacted by the Police to ask for their permission utilise their statements in the writing of this report. In all instances, permission was denied.

[5] As a Serious Incident Investigation Report had been written by Camden & Islington NHS Foundation Trust, this was accepted in lieu of an IMR

8.5. Involvement of family and friends

8.5.1. The family of the victim were informed about the commencement of the DHR and invited to participate. Prior to meeting (whilst the criminal investigation was still on-going) contact was made through the Family Liaison Officer (FLO) which allowed them an opportunity to comment on the terms of reference. Once criminal proceedings had concluded, the Chair met with the family and their advocate from Advocacy After Fatal Domestic Abuse (AAFDA).

8.5.2. Regular updates continued after this meeting and an invitation was extended for them to meet with the Panel which took place on May 21st. At this stage, information had yet to be obtained from Barnet Enfield & Haringey Mental Health Trust.

8.5.3. A copy of the draft report was sent to them prior to submission to the Home Office and their comments and views have been incorporated into subsequent versions.

8.5.4. Jayne's family declined to share background information about Jayne. This was for two reasons: they wanted the DHR process to remain focused on Isaac as the person whose actions warranted scrutiny, and the actions of professionals charged with managing someone who had already unlawfully killed twice.

8.5.5. The second reason they gave was because Jayne was a private person in life and did not easily share personal information about herself outside of her close family members. She was widely liked and was always willing to help others but rarely confided her thoughts and feelings. Her family wanted to continue to respect her privacy as they had done when she was alive.

The Panel agreed to respect the wishes of the family insofar as possible.

8.5.6. Post-conviction, the perpetrator was contacted through his Offender Manager and invited to participate. The Panel were informed that Isaac was too unwell to participate.

9. Key events

9.1 Jayne was a resident of London Borough of Haringey where she lived with her adult son and his children. She had four children in total; two sons and two daughters. She was 51 when she was murdered. She was largely unknown to services other than her GP; there were no significant tenancy issues, she was unknown to local domestic abuse services and although there had been some tangential contact with Children's Social Care, this was only as a relative and not relevant to this DHR.

9.2 Isaac was born in Jamaica, the fifth child and first surviving son of eleven children. After leaving school aged 14 he worked in a variety of jobs and aged 17 he began an apprenticeship in French Polishing, which he completed and continued to work for the same company until 1980 when he left to come to UK. Isaac met his first wife when he was just 19. They subsequently married and had two sons; one in 1975 and a second the following year. In 1973, he received a prison sentence for possession of marijuana. In 1978, Isaac's wife came to the UK (where she had been born although she grew up in Jamaica) leaving Isaac and the two young boys in Jamaica. In 1980, they were all reunited in the UK.

9.3 In 1981, Isaac states that he had an argument with his wife which started when his wife would not let him go to church because he was 'not dressed well enough'. Isaac alleged that his wife attacked him with a broom and a fight ensued. Isaac hit his wife with an ashtray and

a glass vase. The argument spilled out onto the balcony. Isaac lost his temper and pushed her over the edge. She died from her injuries.

9.4 Isaac was convicted of manslaughter on the grounds of provocation and was sentenced to three years imprisonment, of which he served 22 months. At his trial, the judge remarked that Isaac was 'not a violent man'.

9.5 The year he came out of prison, Isaac began a new relationship and they soon moved in together. A year or so later, Isaac moved from Wolverhampton where they had been living, to London in search of work. Isaac was convicted of possession of class B drugs 1987 and again in 1988 and for theft in 1989.

9.6 A few years later, his new partner joined him in London and they had a daughter together in 1990. In 1992 the couple separated but it is thought they continued to share accommodation in the weeks that followed. At one point, his partner sought police help to get Isaac to leave their home. A few days later, Isaac strangled her to death with a belt as their two year old daughter slept. He left the flat soon afterwards leaving his child with the body. He later drove to Cheshunt where he dialled 999 and reported his crime. Isaac then attempted suicide by trying to hang himself from a tree with string. This was unsuccessful.

9.7 Following his arrest, Isaac was transferred to an interim secure unit under section 48/49 of the Mental Health Act He was found to be depressed, and at the time was hallucinating and suicidal. He was treated with antidepressant and antipsychotic medication, and subsequently saw a psychotherapist.

9.8 In March 1993, he was convicted at the Old Bailey of killing by diminished responsibility and was sentenced to a section 41 Mental Health Hospital Order. Both prosecution and defence agreed he was unfit to stand trial. He was sent to a Secure Hospital.

9.9 In the early part of 1994, Isaac experienced a second period of depression although he recovered without taking any medication. He was prescribed anti-depressants but refused to take them.

9.10 After Jayne's murder, a health care assistant at the Secure Hospital said: *'I was waiting for this to happen. He was a very charming man who worked the system. While inside he was talking to girls outside, we all knew his past but he was well-liked and people were prepared to pull a blind eye.'* She stated that Isaac was given unescorted parole every other weekend during his stay at the hospital. He was later (1995) given permission to have unescorted leaves to attend a local college and it was here that Isaac met Jayne where they were both attending the same course. This was the first time that Isaac was not in an artificial environment and thus the conditions which would later form part of his release could be tested. This opportunity was not taken; the college were not notified of any risk he may pose to the female students and no information was sought as to whether he had formed any relationships. Reports at the time state that there was no evidence of untoward behaviour but the mechanisms for identifying this appear not have been put into place.

9.11 A record of a case conference held in March 1996 makes explicit the need for regular monitoring in the community to include regular home visits some of which needed to be unannounced. It acknowledges the necessity of a degree of intrusiveness in this process. It is not clear that this acknowledgement and requirement were included explicitly in any subsequent care plans. There may have been an assumption that unannounced home visits would be an implicit requirement of any attempt to ensure that Isaac was being truthful in denying any relationship with women.

9.12 In May 1996, Isaac's clinical team recommended that he be given a deferred conditional discharge pending suitable accommodation being found. The Mental Health Tribunal refused this

application as they had concerns that Isaac had deceived the team by having at least one clandestine relationship with a woman from the Multidisciplinary Team which he denied when challenged. This was detailed in the Social Worker report to the Tribunal. He subsequently had two sessions with the Chartered Clinical Psychologist during which he openly discussed his platonic relationships with five women which he claimed had been misinterpreted as being romantic liaisons.

9.13 In October 1997, another Mental Health Tribunal heard his case and this time he was conditionally discharged with the following conditions:

1) To reside at a specific address as directed by his medical and social supervisors.
2) To attend appointments with the responsible medical officer as directed and accept such treatment plan as prescribed.
3) To attend appointments as directed by his social work supervisor.
4) To disclose to both his medical and social supervisor any relationships with women and to accept that such disclosure will involve his past history being communicated to such a person.
5) To not make any unauthorized contact with the victim's family.

9.14. Comments in the reports submitted to the Tribunal imply the need to be cautious about accepting Isaac's account of his behaviour but the conditions for discharge do not explicitly express the need for unannounced visits unlike the statements in the case conference from March 1996.

9.15. Successive risk management plans centred on maintaining the conditions as laid out in his conditional discharge and in particular regularly asking Isaac if he was in a relationship. This pattern continued though changes of team and changes of personnel for the next twenty years.

9.16 The following month Isaac was admitted to 24 hour staffed accommodation and BEHMHT had no further contact with him.

9.17 North London Forensic Service, which has since been restructured, had responsibility for Isaac from 1997-2005. Some of the missed opportunities identified by Jayne's family occurred during this period (see paragraph 12.2). Files relating to this service have since been distributed across a number of different organisations so it has not been possible for the Panel to seek an organisational response although where available, files relating to Isaac have been included.

9.18. In practice – at least from 2004 – the conditions of discharge meant that Isaac had to attend three month reviews with a forensic psychiatrist and that he would be assigned a Mental Health Social Worker who would make Home Visits. A care plan from July 2004 includes plans to continue home visits and specifically indicates that they will be through arranged appointments although a risk assessment plan completed in December 2004 states '*The risk remains high should Isaac enter into a relationship with a cohabitee or partner given his past index offences. The risk remains specific to future partners or cohabitees.'* The intervention section of the form ends with the sentence '*appointments and unannounced visits should also be considered on a regular basis to Isaac's flat.*' In practice, there was not another unannounced visit for eight years.

9.19. Isaac made no reports of any relationships subsequent to his discharge in 1997 although he was asked on many occasions. It is clear with the benefit of hindsight, that Isaac took active steps to conceal his relationship with Jayne. They never lived together and when the police searched his flat after Jayne's murder, there was no indication of a woman living

there apart from a woman's dressing gown (but see paragraph 9.33 below). Equally, there was no indication of Isaac in Jayne's accommodation.

9.20. Isaac registered with his GP in 2001. His GP was aware of his previous history and reviewed his mental health to ensure he had psychiatric follow up. At this point his GP was seeing Isaac approximately once a year.

9.21. In December 2003 Isaac's case was transferred to a new Responsible Medical Officer (RMO) who, like his predecessor, was a Consultant in the North London Forensic Service.

9.22 In October 2004, a meeting of professionals was held and a handover date from forensic to local services was set for 1 December 2004. The plan included a forensic community nurse who would continue to see Isaac and work with the Community Mental Health Team (CMHT) for six months.

9.23 In December 2004, a handover meeting was held attended by the consultant forensic psychiatrist, the Community Mental Health Team (CMHT) consultant psychiatrist, Social Workers, and others from both teams. It was noted that the forensic psychiatrist would be happy to review Isaac after a period of time, and at the stage when a complete discharge was being considered. Towards the later part of 2005, the forensic community nurse withdrew from the case.

9.24 In December 2006 at a Care Programme Approach (CPA) Review, no changes were noted since the previous review. Isaac's past history was briefly reviewed, Isaac denied being in any relationship and agreed to get in contact with his care coordinator should there be any concerns.

9.25 Over the next five years, Isaac attended regular three monthly reviews and the Psychiatric Supervisor and Social Supervisor provided the required quarterly reports. During this period there were a number of changes in personnel.

9.26 In 2006 Isaac was diagnosed with having type 2 diabetes; after this diagnosis his GP saw him at least twice a year and sometimes more often. Most of these were review appointments but did also include a mental health check. Isaac did not always take his diabetic medication, which his GP discussed with him several times. As a consequence, his diabetes was not well controlled but he had a series of blood tests about a week before the murder and all of these were normal.

9.27 The following year the GP did specifically enquire about whether Isaac was in a relationship. Isaac said that he had no present girlfriend and had no plans to do so, he said he was very keen to stay well and not have more problems. He contributed his earlier history to drug problems and said that he had no drug misuse since that time. The GP had no cause to disbelieve Isaac and at no point did Isaac display any signs of mental ill-health.

9.28In 2013, Isaac reported erectile dysfunction to his GP and was prescribed medication. The GP thought this was for masturbatory purposes as no partner was mentioned by Isaac although he was not specifically asked on this occasion. Isaac was prescribed medication for erectile dysfunction twice more: once in 2014 and once in 2015. This information was not shared with anyone else.

9.29 Between August 2013 and November 2015, Jayne regularly saw her GP for depression. She was signed off work, prescribed anti-depressants and referred several times for counselling although she never attended any of the appointments. Jayne had initially felt that she was not ready to participate in psychological therapy but had later agreed with the GP that there was a benefit in trying which was why she was encouraged to self-refer to counselling from September 2014 onwards. She did complete an initial self-

referral in September 2014 and again a year later but in both instances did not respond when the team tried to contact her. There are no further details available regarding the underlying cause of her depression.

9.30. Isaac worked as a driver for a car company and he also owned a shop in Camden where Jayne sometimes helped him out. The former is recorded in his GP notes from 2010 to 2012 although he is also recorded as unemployed between 2010 and 2014. In 2013, Isaac received more than £100,000 as a repayment for money he had contributed towards supported accommodation that should have been paid for under terms of Section 117. Jayne's family were also aware that Isaac part-owned a garage and was working as a mechanic in Haringey. There are no records of this in any professional records; suggestive again of Isaac's on-going concealing of the truth about his life.

9.31 Isaac's social worker and a colleague made an arranged Home Visit in May 2012. There was no evidence of anyone other than Isaac. There was a further Home Visit the following month; this time unannounced because Isaac had missed an appointment in clinic. They had no answer when they called at his flat. The following day he made telephone contact in response to a telephone message they had left. This appears to be only the second time an unannounced home visit had been undertaken; the first took place at some time between 1997 and 2000 (reference is made in the files but without a specific date).

9.32 By October 2014, the Mental Health Clinic were considering Isaac for discharge but when this was discussed with Isaac he expressed some doubts regarding the possible lack of a psychological safety net and seemed unsure about the idea. Nevertheless, a letter was sent to his GP asking her opinion about Isaac possibly being discharged. His GP replied requesting that Isaac not be discharged from their service as she felt '*he was a significant risk and that he should not just be followed up by myself in general practice'*. The letter stated that the GP had known Isaac since 2000 and that although '*his behaviour had never caused any cause for concern. I am sure you will agree that his forensic history is very significant.'*

9.33 The possibility of discharge was again raised with Isaac in March 2015. Isaac spoke of his attachment to his social worker and his GP as the only two caring females of his life apart from his mother. His Consultant Psychiatrist discussed with him the trigger factors that may have led him to murder his two partners and Isaac was eager to specify that he was not a violent man. The Consultant Psychiatrist noted that Isaac seemed to fail to acknowledge the complexities of his relationships with partners and although Isaac described himself as different from when he committed the offences, he was unable to describe what he meant by this.

.

9.34 A care plan was completed by Isaac's Social Worker in October 2015. The risk level was recorded as low, he was categorised as non-CPA[6] and his legal status was recorded as Informal. The summary records his history and describes him very independent in managing his own tenancy and day-to-day life. It goes on to add that Isaac is active and has a close friend with whom he socialises and is in contact with his two adult sons. The conclusion notes that his main risk is if Isaac should enter into a relationship and the plan is based on him keeping to the conditions of his conditional discharge. The document does not indicate how the care plan has been formulated, whether it involved discussions with Isaac, his psychiatrist, or any of his friends and family. There is no indication as to how the risk factor associated with him forming a relationship is to be assessed or managed other than by obtaining Isaac's assertion that he's not in a relationship.

[6] Non-CPA describes the approach used in secondary mental health care to assess, plan, review and co-ordinate the treatment, care and support needs for people in contact with secondary mental health services who do not have complex needs.

9.35 In February 2016 there was an arranged home visit by his Social Worker who was accompanied by a Graduate Mental Health Worker colleague. This was the fifth Home Visit in five years only one of which had not been pre-arranged (see paragraph 9.29). There was therefore a long-established pattern of prearranged visits and regular quarterly meetings in clinic. It was noted that some of Isaac's decorations looked more 'feminine' than they had in the past (wooden blocks spelling out LOVE) and there were two mobile phones. His Psychiatrist was notified to ask him directly at his next appointment nine days later as to whether he was in a relationship. This was done and Isaac denied having any relationships with women since leaving hospital in 1997. He provided a plausible explanation, namely that he was redecorating and also changing his mobile. It is unclear why the Social Worker did not challenge him at the time nor why she did not to ask to see the mobiles. This was a missed opportunity. Had she examined the mobiles, this would have revealed that Isaac was lying and a history of calls and texts between him and Jayne. An appropriate level of professional curiosity may have also triggered a further unannounced visit.

9.36 At his quarterly mental health outpatient appointments, Isaac continued to present well, as having no mental health symptoms, socialising and coping with daily activities (sleeping, eating, etc). This pattern was repeated at his clinic meeting in September 2016 although he also reported a recent visit from his sister and expressed a desire to make contact with his daughter whilst acknowledging that he would need to seek permission from the Ministry of Justice as this would contravene his conditions of discharge.

9.37 Isaac was seen by his psychiatrist a week before the murder for another routine appointment. He noted: '*On assessment today there was no evidence of change in mental state with no evidence of depressed mood or psychotic symptoms and he reports sleep remains intact. However, he did comment on feeling lonely recently and became tearful when discussing this. He told us that a male friend had recently left the country and that his sons had had less contact recently (this is usually infrequent contact) but his activities attending the garage and other supports appeared much the same. We did wonder if there were other losses or changes in his life that he was less keen to discuss with us based on his report today). He said that the current loneliness made him think a lot about his life and how things had never gone right in his life. He denied any thoughts of harm to self or suicide and denies thoughts of harm to others. No evidence of substance use.*

We discussed what he felt might help with how he was feeling at present, he could not identify anything but said that he did think it would be helpful to meet with his Social Worker to discuss this further and think about ways he might want to reduce isolation in the next week or so.' The report goes on to describe Isaac's presentation as being *'well kempt, established eye contact and rapport but tearful at times when discussing feeling lonely. Speech was normal. He was not objectively depressed. There were no psychotic symptoms. He was orientated to Time Place Person. Has insight [into what is going on, here and now]'*

9.38 Isaac did have another appointment with his Social Worker two days before the murder but this was cancelled due to the Social Worker being ill. This was unfortunate given the changes in Isaac's behaviour but was informed by the lack of any serious mental health concerns.

Jayne and Isaac were friends for over twenty years. The victim's family gave conflicting accounts with respect to the nature of their relationship; her children state that it was a romantic relationship whilst her sisters believe it to have been more of a friendship with some periods of romantic involvement. Isaac was described by Jayne's children as abusive and controlling and he once punched her after she found out he had cheated on her. There are no records of this being reported to any agency. Jayne terminated their relationship around August 2016.

9.39 It is not known exactly what caused the relationship to end but an inference can be drawn from the knowledge that Jayne had recently became aware of Isaac's past. She accidentally saw some documentation at his flat which alluded to his mental ill-health and criminal history.

9.40 Subsequent to this, Jayne moved on with her life and had tentatively started to see a new man. Her children report that she had been a lot happier during this time. At one point, approximately five weeks before the murder, Isaac saw Jayne with her new man in the street.

9.41 The evening before the murder, Isaac called and texted Jayne several times, begging her to come over to his flat. One of these calls started at 23.37pm and lasted for over two hours. Jayne told her daughter she was going to see Isaac the next day to accompany him to an appointment at the Jamaican embassy. The police were unable to find any evidence to support this despite checking with immigration. The following morning, Isaac called Jayne again at 7am and about an hour later, Jayne left her home and took the three buses needed to get to Isaac's flat, arriving at around 9.20am. Whilst in transit, she called Isaac again, presumably to say that she was on her way. It would be the last call she ever made.

9.42 At 1.30pm, CCTV recorded Isaac in his car, travelling out of London towards Cheshunt. He arrived at Cheshunt station about ten minutes later and after walking around the station for over an hour, jumped in front of a train at 15.16. This was witnessed by an off-duty police officer.

9.43 Emergency Services were called and Isaac was taken to the Royal London Hospital (RLH) by Air Ambulance. His injuries were not life threatening but they were life changing. Isaac's right arm was severed during the incident and his left arm was so injured that it subsequently had to be amputated above the wrist. As a consequence he stayed in the Royal London Hospital for the best part of a month.

9.44 Later that day, Jayne's son called her and got no answer. He subsequently called the police to report that he had been trying to contact his mother but had been unable to get any answer. He said that she had been with Isaac, her ex-partner, that morning. He told police that there had been previous domestic abuse issues between them before they had separated about two months ago. He stated that Isaac was reportedly trying to restart their relationship.

9.45 British Transport police officers at the scene recovered a car key and subsequently identified Isaac's car parked in the station car park. From this, they were able to identify Isaac's home address which officers went to in an attempt to identify a next of kin. Entry was gained using the keys recovered from Cheshunt Station. Inside they found Jayne's lifeless body along with obvious signs of violence. An ambulance was called and the Metropolitan Police were notified. An attending paramedic pronounced life extinct at just before 8pm. A post-mortem examination established her cause of death to be neck compression by strangulation with a ligature and blunt force trauma to the head.

9.46 On 19th January 2017, Isaac was released from hospital into police custody. He gave a no comment interview but was still charged with murder.

9.47 The trial had been scheduled to take place on Tuesday 2nd January 2018 and indeed began to get underway with jury selection. Isaac then interrupted proceedings and asked to speak to his barrister which resulted in a change of plea from guilty to manslaughter to guilty of murder. He was duly convicted and was sentenced to life imprisonment with a recommendation he serve at least 26 years.

9.48 In March 2018, the Court of Appeal heard an application by the Solicitor General regarding the sentencing of Isaac. The Solicitor General appealed the sentence on the basis it was unduly lenient. The Court of Appeal heard the application and agreed with the Solicitor General. Isaac's minimum term of imprisonment was increased to 30 years.

10. Analysis

The Individual Management Reviews have been carefully considered through the view point of Jayne, to ascertain if each of the agencies' contacts was appropriate and whether they acted in accordance with their set procedures and guidelines. Where they have not done so, the Panel has deliberated if all of the lessons have been identified and are being properly addressed.

The Review Panel is satisfied that all agencies have engaged fully and openly with the Review and that lessons learned and recommendations to address them are appropriate.

The authors of the IMRs and Reports have followed the Review's terms of reference carefully, and addressed the points within it that were relevant to their organisations. They have each been honest, thorough and transparent in completing their reviews and reports.

10. 1. Each agency's involvement with the victim January 2014 to December 2016.

This is detailed in the narrative chronology above.

10. 2. Each agency's involvement with the perpetrator from 1993 onwards.

This is detailed in the narrative chronology above.

10.3. Whether, in relation to either Jayne or Isaac, an improvement in communication between services might have led to a different outcome for Jayne.

The Panel noted that despite Tadalafil being issued for erectile dysfunction in general and not just for use with another person, they still would have expected the request to trigger a question about whether he was in a relationship and to have recorded the answer even if it was likely to have been a denial from Isaac as he did when asked by others.

Not all information was transferred adequately. At one point, Isaac's psychiatrists experienced significant difficulties in obtaining Isaac's previous records and this influenced their ability to gather a comprehensive understanding of his past history.

10.4. Whether the work undertaken by services in this case was consistent with each organisation's professional standards.

The GP's for both Isaac and Jayne provided good and consistent care.

Mental health services for Isaac did meet their professional standards – for mental health services. As has been noted elsewhere, however, they were ill-equipped to manage some like Isaac whose risks were not principally related to his mental health issues. As a consequence, levels of professional curiosity should have been heightened and this is discussed further in paragraphs 12.2 and 12.3.

10. 5. Whether the work undertaken by services in this case was consistent with each organisation's domestic violence policy, procedures and protocols.

Not all of the agencies had domestic violence policies and procedures at the time of the events in question. However, all participating agencies do now have these.

10. 6. The response of the relevant agencies to any referrals relating to Jayne, concerning domestic violence, stalking and harassment or other significant harm from Isaac. It will seek to understand what decisions were taken and what actions were carried out, or not, and establish the reasons. In particular, the following areas will be explored:

(a) Identification of the key opportunities for assessment, decision making and effective intervention in this case from the point of any first contact onwards.

(b) Whether any actions taken were in accordance with assessments and decisions made and whether those interventions were timely and effective.

(c) Whether appropriate services were offered/provided and/or relevant enquiries made in the light of any assessments made

(d) The quality of the risk assessments undertaken by each agency in respect of Jayne and Isaac.

No agency was aware that Jayne and Isaac were ever in a relationship; in part because Isaac took active and deliberate steps to conceal this and in part because the mechanisms in place for uncovering any relationship were weak and ineffectual. With the benefit of hindsight, it is now clear that Isaac had been breaching the conditions of his discharge for many years. This suggests that the information about his underlying psychological functioning, his ability to mislead the clinical team, and his lack of insight into his own responsibility for his actions would have been relevant in making an evaluation of the risks and in formulating a suitable risk management plan. By 2014 when Isaac was being considered for discharge, this was based entirely on Isaac's self-reporting which was accepted at face value. Had there been a full re-evaluation of Isaac's circumstances, this should have included an evaluation of his social supports such as the friends he spoke about at review meetings, his sons and members of his family. This may have brought to light discrepancies in his accounts.

After the murder, Jayne's children did report that Isaac was very controlling and had assaulted her on at least one occasion. Although highly speculative, it is possible that her period of depression was related to this. There is nothing in her medical records to indicate if she was ever screened for domestic abuse despite the high correlation of depression in women and experiences of domestic abuse. Her GP did refer her for counselling which Jayne chose not to pursue.

10. 7. The response of the relevant agencies to any referrals relating to Isaac, concerning any other behaviour (including domestic violence, stalking and harassment or other significant harm) from Isaac to any other women. It will seek to understand what decisions were taken and what actions were carried out, or not, and establish the reasons. In particular, the following areas will be explored:

(a) Identification of the key opportunities for assessment, decision making and effective intervention in this case from the point of any first contact onwards.

(b) Whether any actions taken were in accordance with assessments and decisions made and whether those interventions were timely and effective.

(c) Whether appropriate services were offered/provided and/or relevant enquiries made in the light of any assessments made

(d) The quality of the risk assessments undertaken by each agency in respect of other women and Isaac.

From a little over a year after Isaac was first detained under the Mental Health Act, preparations were already being made for his eventual release, starting with unescorted access to the grounds of the hospital and graduating from there. By 1995 he was permitted unescorted visits into the community, including to the college where he met Jayne. His first consideration for release in 1996 was denied as he was suspected of having formed romantic liaisons which he denied when challenged. These concerns had disappeared by the following year and he was released with the ultimately ineffective conditions outlined earlier. The remaining paper trail detailing the risk assessments taken at each of these stages is very sparse and is certainly insufficient to make a proper assessment. Nevertheless, the fact that a man who had unlawfully killed two women was being rehabilitated into the community so soon, with limited safeguards in place, was a matter of well-founded incredulity for Jayne's family.

Obviously, monitoring Isaac in the community was a more complex task than when he was detained. Risk assessments, however, were largely informed by Isaac self-reporting and through observations at pre-arranged meetings. In terms of working with domestic abuse perpetrators, such practice breaches basic minimum safety requirements.[7] The problem, of course, was that Isaac was not viewed as a domestic abuse perpetrator but as a man who had been temporarily mentally unwell but who was now recovered and thus not a risk.

10. 8. The quality and quantity of training provided by services to their staff to enable effective implementation of responses.

Isaac's GP surgery had had IRIS[8] domestic abuse training. Unfortunately this model currently only trains health staff to recognise and respond to victims; work is currently underway nationally to expand the model to also respond effectively to perpetrators of domestic abuse.

Jayne's surgery has also had IRIS training but this did not take place until after the period when Jayne was presenting with depression and thus was more likely to be routinely screened.

Domestic abuse training is also now implemented across BEHMHT and Camden & Islington NHS Foundation Trust. In both instances, however, training is focused on identifying and supporting survivors rather than identifying and challenging perpetrators.

10. 9. Whether thresholds for intervention were appropriately calibrated, and applied correctly, in this case.

As no agency was aware that Isaac and Jayne were in a relationship, no thresholds for intervention were ever considered. This is separate from whether Isaac was appropriately managed which is discussed in detail elsewhere in this report.

10. 10. Whether practices by all agencies were sensitive to the ethnic, cultural, linguistic and religious identity of the respective family members and whether any

[7] Respect National Standards: http://respect.uk.net/wp-content/uploads/2017/02/Respect-Standard-15.11.17.pdf

[8] IRIS is a primary care model for responding to victim-survivors of domestic abuse

special needs on the part of either adult were explored, shared appropriately and recorded.

All nine protected characteristics in the 2010 Equality Act were considered by the DHR Panel. Several protected characteristics were found to have relevance to this DHR. These were:

Marital status: Jayne and Isaac were not married nor were they co-habiting at any stage. Nevertheless, Jayne occupied the group which experiences the highest rate of domestic homicide, namely the recently separated.

Ethnicity: Isaac was of Jamaican origin but married a British citizen (his first wife). Jayne was Black British. There is no indication that their ethnicity impacted on the services they received or sought.

Sex: Sex is also relevant as there is extensive research to support that in the context of domestic violence, females are at a greater risk of being victimised, injured or killed[9]. Latest published figures show that just over half of female victims of homicide in the UK aged 16 or over had been killed by their partner, ex-partner or lover (54%). In contrast, only 5% of male victims aged 16 or over were killed by their partner, ex-partner or lover. Isaac had unlawfully killed two women before Jayne and was clearly a danger to women with whom he was in an intimate relationship.

Disability: Isaac was under the care of Mental Health services for over two decades which in theory, 'qualifies' him as having a disability. However, no signs of mental ill-health were detected after 1994 when he had a brief bout of depression from which he recovered with no medication. Indeed, Isaac was discharged from the CPA process in 2012 on the basis that he did not have a severe and enduring mental illness and thus did not fit the criteria for CPA. There is no evidence that the decision to discharge from CPA was discussed with the Ministry of Justice or that they were specifically informed of the decision.

It is not within the capacity of this DHR to make a retrospective diagnosis to determine if indeed Isaac ever had mental health issue of a level that would qualify as a disability but it does raise questions about the appropriateness of his supervision by Mental Health services rather than the criminal justice system.

10. 11. Whether issues were escalated to senior management or other organisations and professionals, if appropriate, and in a timely manner.

In 2013, Isaac was prescribed Tadalafil tablets to help with erectile dysfunction after being referred to a hospital team for prostrate problems. It not clear if the hospital teams were aware of Isaac's forensic history, that he was subject to three monthly reviews by the Mental Health team and that he had a condition of being obliged to reveal if he was in a relationship. The Panel felt this information should have been highlighted.

The SII report found that it was unclear if there had been any recent discussion of Isaac in supervision, nor could anyone remember him having been discussed in the Team Meeting. It goes on to note that Practice Supervision provides a forum in which there is an opportunity to re-examine the thinking behind management of long term patients, but when under pressure it is those patients that are likely to be displaced by more immediately pressing cases. The Trust Policy on Supervision is due to be reviewed and a recommendation is made to address this as part of the review.

[9] Smith, K. et al. (2011) Homicides, Firearm Offences and Intimate Violence 2009/10. Home Office Statistical Bulletin 01/11. London: Home Office

10. 12. Whether the impact of organisational change over the period covered by the review had been communicated well enough between partners and whether that impacted in any way on partnership agencies' ability to respond effectively.

As would be expected over the course of more than 20 years there were several changes of services, and of professionals working with Isaac. There were example of teams endeavouring to minimise disruption but inevitably these changes had an impact. In the case of the team where he finally ended up, it meant that Isaac was a distinct outlier in terms of his profile when compared to the majority of patients under that team.

While under the care of the Forensic Service there were five changes in consultant and two Social Workers. Once under the care of the Trust there were six changes in responsible consultant and three different Social Workers.

Most of these changes occurred at times when the individual practitioners were taking over an entire caseload from their predecessor. The new clinicians were therefore dependent on receiving advice about which of their patients should be considered a priority. Despite Isaac's status under the Mental Health Act, in practice and when thought of in clinical terms, he was seen as stable, and in comparison to the more acutely unwell patients on the caseload, not presenting as high priority. The pattern of handovers including those from before Isaac's move into the community, and while still under care of the forensic service including the description of mental health concerns and risks is relatively low-key. Although information about his original psychopathy classification (from 1993), his tendency for unreliability and the earlier plans for more assertive supervision are available in the notes, handover notes and CPA records tend to minimize issues of mental disorder and the need to monitor anything other than the conditions of his Section 37/41. This meant that each time Isaac's case was transferred, past management plans tended to be followed without critical review.

Nevertheless, Isaac did have a long standing relationship with his GP and also with his final Social Worker. He mentioned several times that these two woman were the only females he could trust other than his mother. It is thus perhaps notable that at the time of the murder, Isaac was in the process of being transferred to a new GP surgery. This was not of his own volition and related to boundary areas for his existing surgery.

10. 13. Were there any concerns amongst family / friends / colleagues or within the community and if so how could such concerns have been harnessed to enable intervention and support?

Jayne's family rejected the parameters of this question pointing out that it was professionals who put Isaac in a position where he met Jayne. The family were not involved. It thus remains unclear if any family members did have concerns but it is clear from conversations with them that had they done so, they would have known how and where to seek support.

11. Good practice

No examples of good practice were noted.

12. Key findings and lessons learned

12. 1. Mental health provision

A recent report by the Parliamentary and Health Service Ombudsman revealed the dire state of mental health services. There are 5,000 fewer mental health services now than in 2010,

mental health spending fell between 2010 and 2015 and the number of mental health nurses fell 13% between 2009 and 2017, and England's 53 mental health trusts are short of about 10% of staff. The Ombudsman has also found that NHS mental healthcare staff can lack the capacity, skills and training they need to do their job effectively, and do not always have the support they need to learn from mistakes.[10]

The report lists five common failings, two of which are relevant to this case:

- Inappropriate hospital discharge and aftercare of the patient
- Poor risk assessment and safety practices

Clearly the scope of this DHR covers a much longer period than these recent reports. Nevertheless, mental health has been dubbed the 'Cinderella service' of the NHS for many years and staff cannot be expected to deliver a safe and effective service whilst chronically underfunded and understaffed.

12. 2 Lack of professional curiosity

While there was a regular evaluation of Isaac's mental state there is nothing to suggest that there was any re-evaluation of diagnosis or long term management plan. The expectation was that at some point Isaac would be discharged from the Section 37/41. This was first approached by the Supervising Psychiatrist in his report to the Home Office in October 2007, but he received the reply

> '*We note that you feel that Isaac is ready for absolute discharge. While not wishing to minimize his good progress, we do have concerns about this proposal in the light of the fact that he has not been tested in a relationship and this is a high risk factor.'*

Reports as far back as the mid 1990's note that Isaac could be very charming but rather than this alerting professionals to be more aware of how he may be being manipulative, it seemed to lull them in a false sense of security. Throughout the period under review, Isaac was perceived first and foremost as someone with a mental health problem and the nature of his crimes seemed to recede into the background. Professionals need to be alert to the fact that it is entirely possible for someone to experience mental ill-health and be an abuser rather than, as appears to have happened in this case, it being either /or. The fact that in both instances of Isaac unlawfully killing, it was his female partner and that there were no recorded instances of him being violence to anyone else, should have raised red flags about the specificity of his targets.

Jayne's family have provided a number of examples when it may have been possible for Isaac's deception to have been uncovered. These include:

- The college he attended whilst on unescorted leave from Chase Farm could have been alerted to provide any information about Isaac forming a relationship with any fellow pupils
- Isaac previously lived in a housing association property. This property was a basement flat which was flooded on at least three occasions often rendering the property uninhabitable for long periods of time. No checks appear to have been made as to where Isaac was staying in the meantime (he was at Jayne's home)
- If the checks on Isaac had included speaking to his social network or even his neighbours.
- Isaac was under observation for prostrate cancer. He was admitted to Royal Free Hospital for investigation. Jayne assisted him with his admission and visited the hospital frequently to provide support to him. No questions appear to have been

[10] Maintaining momentum: driving improvements in mental health care Parliamentary and Health Service Ombudsman March 2018

asked about their relationship.

- Had this relationship been noted, it may have also triggered more suspicion about Isaac's subsequent request for Tadalafil.
- An examination of his mobile phone would have revealed he was in constant contact with Jayne; the failure to do this was particularly noteworthy after it was discovered Isaac had two mobile phones. It should be noted that Camden & Islington NHS Foundation Trust believe they did not have the legal authority to do this.
- An increase in the number of unannounced visits rather than relying on Isaac self-reporting

12. 3 Questionable risk assessments

There were no suspicions that Isaac was in a relationship because the mechanisms for raising those suspicions were fatally weak, namely relying on self-reporting and scheduled visits. As Jayne's family noted, announced visits gave Isaac the opportunity to hide what needed to be hidden. Risk assessments focused on monitoring his mental health and in the absence of any symptoms, he was treated as low risk. This was entirely the wrong focus.

12. 4 Similarities in killing methods

The Panel noted similarities between the second and third killing most notably:

- A ligature was used in both; a leather belt in the second and a belt from a dressing gown in the third
- The perpetrator drove to Cheshunt after the attacks.
- He attempted suicide after both killings.
- In both instances the women had begun new relationships

12.5 Poor consequences for unlawfully killing two women

For the first killing, Isaac served 22 months in prison. For the second, he was detained under the Mental Health Act for four years and eight months. This totals a mere six and a half years that Isaac lost his liberty for the unlawful deaths of two women. The Panel felt that this sent entirely the wrong message regarding the value of a woman's life and more importantly, to Isaac about the gravity of his actions.

12.6 Reliance on self-reporting to manage risk

Depending on Isaac to reveal he was in a relationship was both naïve and inadequate especially given that he was well aware of the consequences of doing so, namely that the woman concerned would be informed and that he potentially faced a recall to an institution.

That self-reporting was a condition of his discharge gave it a legitimacy to his subsequent Social Workers and psychiatrists that it simply did not deserve. The record of a case conference in March 1996 explicitly notes the need for regular monitoring in the community, including regular home visits some of which needed to be unannounced. It acknowledges the necessity of a degree of intrusiveness in this process. Additionally, the reports prepared for the Mental Health Tribunal in 1997 indicate Isaac's inconsistency and unreliability in reporting to members of staff. It is unclear why the suggestions outlined in these reports were not reflected in the formal conditions for discharge.

As far as can be established from the records, Isaac had a total of three unannounced visits once discharged. On one of these occasions, he was not in. It is simply astonishing that these were the only attempts beyond asking Isaac himself, to verify that a double killer was telling the truth.

12.7 The lack of an appropriate community service to monitor Isaac

In the end, Isaac was being monitored by a Mental Health team (South Islington Rehabilitation and Recovery Team*)* whose clients mostly have an underlying diagnosis of psychosis. The presence of this plays a major role in assessing risk and the apparent absence of any mental health issues, still less of psychosis, undoubtedly played a role in Isaac being seen as low risk. In reality, the risk that Isaac posed was not related to him having a mental health issue and as such, risk assessments needed to place less emphasis on this. Given that the service was ill-suited for someone of Isaac's circumstances, it is difficult to understand why a referral to MAPPA was never considered after they were established in 2000 rather than the trend towards discharge. As well as unannounced visits, MAPPA is also empowered to undertake more intrusive surveillance should they deem it necessary to manage the risk. Camden & Islington NHS Foundation Trust state that this was not considered as Isaac's offences pre-dated MAPPA and in the absence of any information to indicate that Isaac was in a relationship and thus a risk, felt there was no basis on which a referral could be made.

12.8 Separation as a risk factor / catastrophic responses to loss

It is well established that the end of a relationship is a common time for domestic homicides to occur. In this case, Jayne had ended the relationship a few months before the homicide and had recently started to see a new man. Isaac became aware of this a few weeks before the murder. Isaac was also experiencing other losses in his life; his long-standing relationship with his GP, seeing his sons less frequently and a close male friend who had recently moved away. This is not intended to serve as an excuse; merely to note that many abusers come to believe that having absolute control is key to their well-being. As such, this constellation of losses may have been a contributory factor to the murder. In terms of monitoring similar individuals in the future, greater attention should perhaps be paid when they speak of losses.

12.9 The intersection of the Criminal Justice System and Mental Health

The relationship between the health and justice systems in a case such as this, where someone who has been found guilty of a serious crime has been judged to have been mentally unwell at the time that he committed it is not an easy one to safely navigate. The appropriate treatment of such an offender raises issues about the extent to which he was responsible for his actions and posed a continuing danger to other people.

It does seem to the Panel that at present, there is too sharp a demarcation between the 'planets' of justice and of mental health. Despite some of the efforts to forge a link, such as MAPPA, there seems to be an assumption that once someone has been assigned to hospital rather than prison, their care becomes essentially a medical task – one of cure rather than custody. Judgements about the patient's release would appear to be made largely on the basis of managing stability in their mental health, with limited regard either to culpability for the original offence or even to the danger that they might pose to others when out in the community. The Panel were advised by the National Probation Service that even now, MAPPA rarely receives referrals from Hospital Trusts.

How then should someone like Isaac be managed? The Panel felt the divide between justice and mental health is too simplistic: does the fact that someone is mentally unwell automatically absolve that person of all responsibility for their actions, however grave their consequences? Can even apparently successful treatment of their mental condition assure the public that they no longer constitute any risk, when they have previously shown themselves capable of killing someone? The latter question is all the more pertinent when

the individual's risk to others is dependent on a regime of self-disclosure with which it is very difficult to monitor their compliance in a non-institutional setting. The Panel felt that Isaac should have been subject to more frequent unannounced visits and these may have been enhanced had they been joint visits with someone – such as Probation Services – with a greater focus on offenders. Unfortunately, the sharp demarcation between the 'planets' means that Probation Services had no input at all into Isaac's case.

Whilst there are obviously actions that can be taken locally, the issues outlined above can only be adequately addressed at a national level. Much closer collaboration is needed between Mental Health and the CJS and more dialogue is needed to ensure that both sectors have a shared understanding of what exactly is being referenced when they speak of 'risk'. Care too will be needed not to exacerbate the stigma already faced by those who suffer from mental ill-health. Nevertheless, it simply cannot be right that a man who has unlawfully killed two women should forego his liberty for a few short years only to be released to kill again with the only safeguard having been that he himself would report his risk to the authorities.

13. Recommendations

Single agency recommendations:
Islington CCG

- GPs to be reminded to be vigilant when prescribing medications that started from hospital, especially when the patient has a forensic history
- GPs to be reminded that if they are part of the system for monitoring whether a patient is in a relationship, they should record when they asked and what the response was
- GPs to be reminded that if they are part of the system for monitoring whether a patient is in a relationship that any requests for erectile dysfunction medication should be shared with the appropriate authorities even if there is an ostensibly valid reason.

Camden and Islington NHS Foundation Trust

- The Trust identify all patients subject to Section 37/41 who are currently being managed by community services and who have not had a comprehensive review of their mental health history in the previous five years.
- The consultant psychiatrist in conjunction with the care coordinator undertakes a comprehensive review of the past record and current actual social circumstances of each such patient and provides a summary in the clinical record.
- The assessment based on this information is used to reassess the diagnosis, produce a comprehensive care plan including a current risk assessment and risk management plan.
- Following a suitable interval an audit takes place to demonstrate that all such patients have been reviewed in this way.
- The Trust develops and maintains a central record of patients eligible to receive aftercare under Section 117.
- The electronic clinical record system is modified so that this information is included in the record of care plans.
- Care planning for this group of patients is managed using the CPA process.

- The Trust routinely audits that the record is up to date and accurate.
- The Trust, in conjunction with forensic services from which they accept patients develops a protocol for the referral and transfer of patients between services.
- The protocol contains standards for the quality of clinical information, risk and care plans, and the time frame that is considered acceptable.
- The Trusts audits the impact of implementation of this protocol on the service.
- The Trust review the Clinical Professional and Practice Supervision Policy.
- The revised policy contains a requirement that patients cared for under CPA or subject to the Mental Health Act and care coordinated by the supervisee should be discussed in supervision at least once per year.

There were three additional recommendations made as follows:

- Before undertaking any significant reorganisation of services the Trust ensure that an assessment of risks arising out of the proposals is carried out and a means to implement a risk management plan to minimise any adverse outcomes identified.
- The assessment identifies patients whose needs cannot be adequately met by the reconfigured service and a strategy developed to manage this deficit.
- The action plan arising out of this assessment is included in any proposal for reorganisation, and its implementation monitored by Trust Governance procedures.

However, Camden & Islington NHS Foundation Trust rejected these recommendations stating that they did not accept there was sufficient evidence that service reconfiguration had impacted on Isaac's care. They also pointed to an existing Quality Impact Assessment Procedure which considers the impact on and potential risks to services users of significant service changes which is used to create action plans to mitigate these.

Multi-agency recommendations

Haringey Safer Communities partnership to keep the victim's family updated on a six monthly basis on the implementation of the action plan.

Domestic abuse training for local professionals to be reviewed to ensure it includes a focus on identifying and responding to perpetrators.

National recommendations

Ministry of Justice to implement a requirement for evidence to be provided additional to self-reporting that persons subject to a condition not to be in a relationship are compliant with said condition. Evidence must include regular unannounced visits.

Ministry of Justice to undertake an urgent review of all similar cases to ensure that risk is being adequately managed.

Home Office to work with the Ministry of Justice to develop guidance for local agencies on the management of domestic abuse perpetrators who are released into the community subsequent to a detention under the Mental Health Act.

Appendix A: Terms of Reference

DOMESTIC HOMICIDE REVIEW (DHR) into the death of Jayne

TERMS OF REFERENCE

Overarching aim

The over-arching intention of this review is to learn lessons from the homicide in order to change future practice that leads to increased safety for potential and actual victims. It will be conducted in an open and consultative fashion bearing in mind the need to retain confidentiality and not to apportion blame. Agencies will seek to discover what they could do differently in the future and how they can work more effectively with other partners.

Principles of the Review

1. Objective, independent & evidence-based
2. Guided by humanity, compassion and empathy with the victim's voice at the heart of the process.
3. Asking questions, to prevent future harm, learn lessons and not blame individuals or organisations
4. Respecting equality and diversity
5. Openness and transparency whilst safeguarding confidential information where possible.

Key lines of inquiry

The Review Panel (and by extension, Individual Management Review authors) will consider the following:

1. Each agency's involvement with the victim January 2014 to December 2016.

2. Each agency's involvement with the perpetrator from 1993 onwards.

3. Whether, in relation to either Jayne or Isaac, an improvement in communication between services might have led to a different outcome for Jayne.

4. Whether the work undertaken by services in this case was consistent with each organisation's professional standards.

5. Whether the work undertaken by services in this case was consistent with each organisation's domestic violence policy, procedures and protocols.

6. The response of the relevant agencies to any referrals relating to Jayne, concerning domestic violence, stalking and harassment or other significant harm from Isaac. It will seek to understand what decisions were taken and what actions were carried out, or not, and establish the reasons. In particular, the following areas will be explored:

(a) Identification of the key opportunities for assessment, decision making and effective intervention in this case from the point of any first contact onwards.

(b) Whether any actions taken were in accordance with assessments and decisions made and whether those interventions were timely and effective.

(c) Whether appropriate services were offered/provided and/or relevant enquiries made in the light of any assessments made

(d) The quality of the risk assessments undertaken by each agency in respect of Jayne and Isaac.

7. The response of the relevant agencies to any referrals relating to Isaac, concerning any other behaviour (including domestic violence, stalking and harassment or other significant harm) from Isaac to any other women. It will seek to understand what decisions were taken and what actions were carried out, or not, and establish the reasons. In particular, the following areas will be explored:

(a) Identification of the key opportunities for assessment, decision making and effective intervention in this case from the point of any first contact onwards.

(b) Whether any actions taken were in accordance with assessments and decisions made and whether those interventions were timely and effective.

(c) Whether appropriate services were offered/provided and/or relevant enquiries made in the light of any assessments made

(d) The quality of the risk assessments undertaken by each agency in respect of other women and Isaac.

8. The quality and quantity of training provided by services to their staff to enable effective implementation of responses.

9. Whether thresholds for intervention were appropriately calibrated, and applied correctly, in this case.

10. Whether practices by all agencies were sensitive to the ethnic, cultural, linguistic and religious identity of the respective family members and whether any special needs on the part of either adult were explored, shared appropriately and recorded.

11. Whether issues were escalated to senior management or other organisations and professionals, if appropriate, and in a timely manner.

12. Whether the impact of organisational change over the period covered by the review had been communicated well enough between partners and whether that impacted in any way on partnership agencies' ability to respond effectively.

13. Were there any concerns amongst family / friends / colleagues or within the community and if so how could such concerns have been harnessed to enable intervention and support?

Family involvement and Confidentiality

The review will seek to involve the family of both the victim and the perpetrator in the review process, taking account of who the family wish to have involved as lead members and to identify other people they think relevant to the review process.

We will seek to agree a communication strategy that keeps the families informed, if they so wish, throughout the process. We will be sensitive to their wishes, their need for support and any existing arrangements that are in place to do this.

We will identify the timescale and process and ensure that the family are able to respond to this review endeavouring to avoid duplication of effort and without undue pressure.

Disclosure & Confidentiality

- Confidentiality should be maintained by organisations whilst undertaking their IMR. However, the achievement of confidentiality and transparency must be balanced against the legal requirements surrounding disclosure.
- The independent chair, on receipt of an Individual Management Review, may wish to review an organisation's case records and internal reports personally, or meet with review participants.
- A criminal investigation is running in parallel to this Domestic Homicide Review, therefore all material received by the Panel must be disclosed to the Senior Investigation Officer and the police disclosure officer
- The criminal investigation is likely to result in a court hearing. Home Office guidance instructs the Overview Report will be held until the conclusion of this case. Records will continue to be reviewed and any lessons learned will be taken forward immediately.
- Individuals will be granted anonymity within the Overview Report and Executive Summary and will be referred to by pseudonyms.
- Where consent to share information is not forthcoming, agencies should consider whether the information can be disclosed in the public interest.

Timescales

All Domestic Homicide Reviews are to be submitted to the Home Office within 6 months of notification. If necessary, a revised timeline will be communicated to the Home Office.

The Review commenced in May 2017, and subject to the conclusion of the Criminal Trial, will reconvene in June 2017, with further meetings scheduled thereafter.

All meetings will be held at Wood Green Civic Centre.

Media strategy

Any media enquiries prior to the conclusion of the trial must be referred to the Metropolitan Police, who will liaise as appropriate with Haringey Community Safety Partnership. Post-trial, enquiries should be directed to the Chair, who will agree a media strategy with Haringey Community Safety Partnership.

It should be noted that Panel Members are representing their agency and as such, this media strategy applies to all staff members of participating agencies. Care should also be taken with self-generated publicity such as tweets and press releases so as not to compromise the independence and integrity of the DHR process.

Chairing & Governance

An independent chair has been appointed to lead on all aspects of the review and will report to the Chairs of Haringey Community Safety Partnership..

A Panel has been convened specifically to overlook the review process. This is a mix of statutory and voluntary sector agencies and includes specialist domestic violence services.

Haringey Community Safety Partnership will sign off the final report and submit it to the Home Office Quality Assurance process.

Agency roles and responsibilities

- Delegate a senior officer to lead on the review on behalf of their organisation
- Senior officers will attend all Panel meetings
- Complete Individual Management Reviews within agreed timeframes
- Contribute to the Review Report.

Information Sharing & Confidentiality

The principles outlined in Haringey Community Safety Partnership information sharing protocol[11] will be applied at all times. In addition to this, further reference will be made to the Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews[12].

[11] http://www.haringey.gov.uk/community/community-safety-and-engagement/crime-and-disorder-information-sharing-protocol

[12] https://www.gov.uk/government/publications/revised-statutory-guidance-for-the-conduct-of-domestic-homicide-reviews

Appendix B: Cross-Government definition of domestic violence

The cross-government definition of domestic violence and abuse is:

any incident or pattern of incidents of controlling, coercive, 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. The abuse can encompass, but is not limited to:

- psychological
- physical
- sexual
- financial
- emotional

Controlling behaviour

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

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.

Appendix C: Further information about the chair and report author

Davina James-Hanman is an independent Violence Against Women Consultant. She was formerly the Director of AVA (Against Violence & Abuse) for 17 years (1997-20014), which she took up following five years at L.B. Islington as the first local authority Domestic Violence Co-ordinator in the UK (1992-97). From 2000-08, she had responsibility for developing and implementing the first London Domestic Violence Strategy for the Mayor of London. A key outcome of this was a reduction in domestic violence homicides of 57%.

She has worked in the field of violence against women for over three decades in a variety of capacities including advocate, campaigner, conference organiser, crisis counsellor, policy officer, project manager, refuge worker, researcher, trainer and writer. She has published innumerable articles and three book chapters and formerly acted as the Department of Health policy lead on domestic violence (2002-03). She was also a Lay Inspector for HM Crown Prosecution Service Inspectorate (2005-10). Davina has authored a wide variety of original resources for survivors and is particularly known for pioneering work on the intersections of domestic violence and alcohol/drugs, domestic violence and mental health, child to parent violence, developing the response from faith communities and primary prevention work.

She acted as the Specialist Adviser to the Home Affairs Select Committee Inquiry into domestic violence, forced marriage and 'honour' based violence (2007-08) and Chairs the Accreditation Panel for Respect, the national body for domestic violence perpetrator programmes. From 2008-09 she was seconded to the Home Office to assist with the development of the first national Violence Against Women and Girls Strategy. Davina was also a member of the National Institute of Health & Care Excellence group which developed the domestic violence recommendations and subsequent Quality Standards. She remains an Expert Adviser to NICE.

Davina is a Special Adviser to Women in Prison and a Trustee of the Centre for Women's Justice.

Appendix D: Single Agency Recommendations and Action Plan

Recommendation	Scope	Action	Lead Agency	Target date	Completion date and outcome
GPs to be reminded to be vigilant when prescribing medications that started from hospital, especially when the patient has a forensic history	Local		Islington CCG	January 2020	
GPs to be reminded that if they are part of the system for monitoring whether a patient is in a relationship, they should record when they asked and what the response was	Local		Islington CCG	January 2020	
GPs to be reminded that if they are part of the system for monitoring whether a patient is in a relationship that any requests for erectile dysfunction medication should be shared with the appropriate authorities even if	Local		Islington CCG	January 2020	

there is an ostensibly valid reason.					
The Trust identify all patients subject to Section 37/41 who are currently being managed by community services and who have not had a comprehensive review of their mental health history in the previous five years.	Local	Senior Service Managers will complete an agreed audit of all those service users open to the Trust who are subject to Section 37/41 being managed by community services.	Camden & Islington NHS Foundation Trust	Completed	Audit results
The consultant psychiatrist in conjunction with the care coordinator undertakes a comprehensive review of the past record and current actual social circumstances of each such patient and provides a		For those service users who meet the agreed criteria the relevant Consultant Psychiatrist and care coordinator will complete a yearly review of treatment, risk and care plans and provide a written summary in the care records. A list will be centrally held by each Division of completed reviews.		Completed	Review of records – specifically the summary record by CP and CC Divisional held list

summary in the clinical record.					
Following a suitable interval an audit takes place to demonstrate that all such patients have been reviewed in this way.		Senior Service Managers will complete a yearly audit of the reviews undertaken and address areas of improvement that are required.		Completed	Audit results
The Trust develops and maintains a central record of patients eligible to receive aftercare under Section 117.	Local	To review the current Trust policy related to Section 117	Camden & Islington NHS Foundation Trust	Completed	Section 117 policy reviewed and amended
The electronic clinical record system is modified so that this information is included in the record of care plans.	Local	To develop a Trust wide central list of all those service users subject to Section 117 aftercare	Camden & Islington NHS Foundation Trust	Completed	Centrally held list
Care planning for this group of patients is managed using the CPA process.	Local	To inform the Carenotes group of this action to ensure that Section 117 status is included within care plans.	Camden & Islington NHS Foundation Trust	Completed	Carenotes working group notes

		As part of the CPA policy review the policy document will need to include a standard to ensure that those subject to Section 117 remain are managed via the CPA process		Completed	CPA policy review completed
The Trust routinely audits that the record is up to date and accurate.	Local	Audit of Section 117 practices are audited on a yearly basis	Camden & Islington NHS Foundation Trust	Completed	Audit results
The Trust, in conjunction with forensic services from which they accept patients develops a protocol for the referral and transfer of patients between services.	Local	The Trust will review is transfer/transition policy relating to patient care.	Camden & Islington NHS Foundation Trust	Completed	Transition/transfer policy reviewed and amended.
The protocol contains standards for the quality of clinical information, risk and care plans, and the time frame	Local	A protocol is developed which focused on the standards required for providing clinical information pertaining to risk, care plans and crisis planning	Camden & Islington NHS Foundation Trust	Completed	Transition/transfer policy reviewed and amended.

that is considered acceptable.					
The Trusts audits the impact of implementation of this protocol on the service.	Local	The Divisions will review clinical documentation to ensure that standards are maintained and areas for improvement are identified and communicated across the Trust.	Camden & Islington NHS Foundation Trust	Completed	Audit results
The Trust review the Clinical Professional and Practice Supervision Policy.	Local	The Trust will review the current supervision policy to ensure that those patients held on CPA are discussed with supervisors at least once a year as a minimum.	Camden & Islington NHS Foundation Trust	Completed	Trust Policy reviewed
The revised policy contains a requirement that patients cared for under CPA or subject to the Mental Health Act and care coordinated by the supervisee should be discussed in supervision at least once per year.	Local	Annual audit of the quality of supervision is undertaken across Divisions	Camden & Islington NHS Foundation Trust	Completed	Audit results – Action plans to improve deficits

The impact of assessment and the recording of clinical presentation on risk management be included in all risk assessment and management training.	Local	To review the 'Keeping the patient safe' training to consider the need for adapting to include record keeping aspects of risk management	Camden & Islington NHS Foundation Trust	Completed	Training reviewed and adaptations recorded
Compliance with this recommendation be audited as part of routine monitoring and audit arrangements.	Local	Bi Annual audit clinical documentation related to risk management and crisis planning.	Camden & Islington NHS Foundation Trust	Completed	Audit results

Appendix E: Multi-agency Recommendations and Action Plan

Recommendation	Scope	Action	Lead Agency	Target date	Completion date and outcome
Haringey CSP to receive six monthly updates on the implementation of this action plan until such time as full implementation has been achieved.	Local	Standing item on CSP agenda	Haringey CSP	On-going	
Haringey CSP to share the above mentioned updates with the victim's family	Local	CSP	Haringey CSP	On-going	
Domestic abuse training for local professionals to be reviewed to ensure it includes a focus on identifying and responding to perpetrators.	Local	Review local training content	LB Haringey and LB Islington VAWG Commissioners	March 2020	
Ministry of Justice to implement a requirement for evidence to be provided additional to self-reporting that persons subject to a condition not to be in a relationship are compliant with said condition. Evidence must include regular unannounced visits.	National	Haringey CSP Chair to write to the Justice Minister enclosing a copy of this report and highlighting this recommendation	Ministry of Justice	January 2020	
Ministry of Justice to undertake an urgent review of all similar cases	National	Haringey CSP Chair to write to the Justice Minister enclosing	Ministry of Justice	January 2020	

to ensure that risk is being adequately managed.		a copy of this report and highlighting this recommendation			
Home Office to work with the Ministry of Justice to develop guidance for local agencies on the management of domestic abuse perpetrators who are released into the community subsequent to a detention under the Mental Health Act.	National	Haringey CSP Chair to write to the Home Secretary enclosing a copy of this report and highlighting this recommendation	Home Office	January 2020	