LONDON BOROUGH OF SOUTHWARK
COMMUNITY SAFETY PARTNERSHIP

DOMESTIC HOMICIDE REVIEW

OVERVIEW REPORT

'BARBARA HUBERT' AGED 33

MURDERED IN SOUTHWARK IN NOVEMBER 2018

REVIEW PANEL CHAIR AND REPORT AUTHOR
BILL GRIFFITHS CBE BEM QPM

23 MAY 2021

Domestic Violence Homicide Review Panel – LB Southwark CSP
'Barbara Hubert' murdered by 'Adam Smith' and both found dead in Southwark In November 2018

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INTRODUCTION

1. This report of a Domestic Homicide Review (DHR) examines agency responses and support given to Ms Barbara Hubert[1] (33), a Slovakian national and resident of Southwark in the London Borough of Southwark (LBS) prior to the discovery in early November 2018 of her death following a fall from her home, an 8th floor flat, and the death by the same method shortly after of her partner, Mr Adam Smith (33).

2. In addition to agency involvement the review will also examine the past to identify any relevant background or trail of abuse before the homicide/suicide, whether support was accessed within the community and whether there were any barriers to accessing support. By taking a holistic approach the review seeks to identify appropriate solutions to make the future safer.

3. The review will consider agencies contact/involvement with the couple from January 2010 to the day of the homicide in November 2018. Any relevant fact from their earlier life will be included in background information.

4. The key purpose for undertaking DHRs is to enable lessons to be learned from homicides where a person is killed because of domestic violence and abuse. For these lessons to be learned as widely and thoroughly as possible, professionals need to be able to understand fully what happened in each homicide, and most importantly, what needs to change to reduce the risk of such tragedies happening in the future.

5. One of the operating principles for the review has been to be guided by humanity, compassion and empathy, with Barbara Hubert's 'voice' at the heart of the process. This was an unimagined and appalling tragedy for Barbara's family and, through the Chair, the Panel offered their heartfelt condolences upon the loss of Barbara. For the family of the perpetrator, news of Adam's actions must have been profoundly shocking, as well as inexplicable, and they have endured loss, for which deepest sympathy is also offered.

TIMESCALES

6. As soon as the homicide was reported to Southwark Council, partners were requested in November 2018 to secure all relevant records of contact with the couple in preparation for a DHR and the Home Office informed. Following further consideration given to the expertise of Panel membership, the Chair was appointed in February 2019. The review began with a Panel meeting on 20 March when Terms of Reference were agreed, and Chronology reports commissioned from all identifiable public and voluntary bodies that may have had contact with the family. At the second meeting on 15 May, Chronologies were reviewed, and Individual Management Reviews (IMR) were commissioned. The third meeting on 7 August reviewed the IMRs received and initiated further enquiries. The process was put on hold for the Inquests that were held at Southwark Coroner's Court on 7 October. For

[1] A pseudonym nominated by her parents. Apart from named professionals, all other names used herein are also pseudonyms

various logistical reasons the next meeting to consider an initial draft of the overview report that set out the narrative was delayed until 16 January 2020. The fifth meeting on 26 February reviewed and debated a second draft. The fourth draft with family views incorporated was circulated in April for electronic feedback due to the Covid-19 pandemic limitations on meetings. A further two versions were generated reflecting feedback until the final version presented via an internet conference to the Southwark Community Safety Partnership Board on 4 June 2020.

CONFIDENTIALITY

7. The chronologies and IMRs are confidential. Information is available only to participating officers/professionals and their line managers.

8. For ease of reference, all terms suitable for acronym will appear once in full and there is also a glossary at the end of the report. The deceased will be referred to herein as Barbara and Adam as appropriate to the narrative. Family and friends that feature in the review are referred by their first name and included in the glossary for reference.

9. The Government Protective Marking Scheme (GPMS) was adopted throughout with a rating of 'Official-Sensitive' for shared material. Either secure networks were in place (gsi, pnn) and adopted (cjsm) or papers shared with password protection. An integrated chronology was provided to all Panel members for review and discussion.

TERMS OF REFERENCE

10. Following discussion of a draft in the first Panel meeting, Terms of Reference (ToR) were issued on the same day (appendix 1) with a chronology template for completion by agencies reporting contact with the family. The ToR set out the methodology for the review, the operating principles and the wider Government definition of domestic abuse, including controlling and coercive behaviour and are set out in full in appendix 2. The main lines of Inquiry were:
    1. Scope of review agreed from January 2010 to date of homicide with any earlier event of significance to be included
    2. Identify relevant equality and diversity considerations, including Adult Safeguarding issues (see paragraph 23)
    3. Establish whether family, friends or colleagues want to participate in the review. If so, to ascertain whether they were aware of any abusive behaviour to the victim prior to the homicide (any disclosure; not time limited). In relation to the family members, whether they were aware if any abuse and of any barriers experienced in reporting abuse, or best practice that facilitated reporting it (Note: Edward Hubert made a statement to the Coroner that the Chair included verbatim in the ToR so that the Panel would seek answers - see also the Preface, paragraphs 14-16, 123-139 and 146-148)
    4. Take account of previous lessons learned in LB Southwark (see paragraph 13)

5. Identify how people in the LB of Southwark gain access to advice on sexual and domestic abuse whether themselves subject of abuse or known to be happening to a friend, relative or work colleague.

METHODOLOGY

11. Under s9 Domestic Violence, Crime and Victims Act 2004, a Domestic Homicide Review was commissioned by LB Southwark Community Safety Partnership and, in February 2019, Bill Griffiths CBE BEM QPM was appointed Independent Chair of the DHR Panel. Tony Hester supported him throughout in the role of Secretary to the Panel.

12. This review was commissioned under Home Office Guidance issued in December 2016. Close attention was paid to the cross-government definition of domestic violence and abuse and is included in the Terms of Reference (appendix 1). The following policies and initiatives have also been scrutinised and considered:
    - HM Government strategy for Ending Violence against Women and Girls 2016-2020
    - Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews published by the Home Office December 2016
    - Domestic Homicide Reviews: Key Findings from analysis of domestic homicide reviews published by Home Office December 2016
    - Southwark Council website and related services

13. In addition, the Chair has studied two prior DHR report commissioned by Southwark for any parallel lessons or repeat lessons to be learned and none were detected.

INVOLVEMENT OF FAMILY, FRIENDS, WORK COLLEAGUES, NEIGHBOURS AND WIDER COMMUNITY

14. The Chair attended the Inquest in October 2019 and with the assistance of the police family liaison officer and a translator met with Barbara's parents, Edward and Susane, who had travelled from Slovakia. The Home Office leaflet for families was provided and, albeit that Barbara's father has a good command of English, the translator highlighted the main features, including the advocacy advice available. In the course of the Inquest, Edward read out a statement and provided the Chair with a paper copy. The content has been included verbatim in the third version of the Terms of Reference in appendix 1. Edward also provided written feedback on the third version of this overview report.

15. Also present was Adam's daughter, Marie then aged 14, supported by her maternal grandmother (MGM) and guardian, Rose, to whom the Home Office family information leaflet was provided and attention drawn to the advocacy service. Shortly after the Inquest, the Chair met with Rose and Rae who is Marie's aunt at their home and they provided a detailed account of their interaction with Adam and Barbara on the afternoon before the fatal incident. Rose was also provided with the third version and gave verbal feedback.

16. As a consequence of questions from the Home Office Quality Assurance process, the Chair again engaged with Rose and Rae in May 2021. They read the final anonymised version of this overview he shared with them and they discussed the relevant content with Marie, who will be 16 in July 2021. Her family feel strongly the review should be published and they asked for her perspective as someone who is named (albeit with a pseudonym) as having been subject to abuse by Adam. In a message to Rose, Marie wrote: *If it will help people in my situation on how to get help and act in that kind of situation then yes I will be okay with that to be published.*

17. The Chair had also met Barbara's friend, Nora, at the Inquest and provided the Home Office leaflet for friends. A meeting was arranged and Nora provided helpful background information and a follow up call. As an 'Interested Person' under the Coroners Act at the Inquest, the Chair was provided with the evidence considered by the Coroner.

CONTRIBUTORS TO THE REVIEW

18. This overview report is an anthology of information and facts from the organisations represented on the Panel, many of which were potential support agencies for Barbara and Adam:

    Primary Care Services – GP Practices for Barbara and Adam (Southwark CCG Panel member and IMR author provided a consolidated IMR for two independent GP surgeries in Southwark and one in Lewisham)
    South London and Maudsley NHS Foundation Trust (SLAM) (provided IMR and specialist mental health advice)
    Guy's and St Thomas' NHS Foundation Trust (G&StTH) (provided chronology)
    Kings College Hospital NHS Foundation Trust (KCH) (provided chronology)
    London Ambulance Service NHS Trust (LAS) (provided IMR and attended the fifth meeting where it was debated)
    Metropolitan Police Service (MPS) (provided letter with chronology)
    LB Southwark Safeguarding Board
    Specialist drug and alcohol addiction advice - LB Southwark Drugs and Alcohol Action Team
    Specialist domestic abuse advice – Solace Women's Aid

THE REVIEW PANEL MEMBERS

19. Table 1 – Review Panel Members, all of whom are independent senior managers

Name	Agency/Role
Hannah Edwards	LB Southwark, Safeguarding Board
Hazel Guha	LB Southwark, Safeguarding Board

Dr Megan Morris	Southwark CCG Named GP Adult Safeguarding
Musthafar Oladosu	Southwark CCG Lead Nurse Adult Safeguarding
Celia John	LB Southwark Adult Social Care
Iain Gray	LB Southwark Drugs and Alcohol Action Team
Sue Eldred	Kings College Hospital NHS Foundation Trust
Michael Fullerton	Guys and St Thomas Hospital Foundation Trust
David Lynch	South London and Maudsley NHS Foundation Trust
Hannah Whittington	LAS Safeguarding Lead for Adults
Graeme Gwyn	MPS Serious Crime Review Group
Amy Glover	Solace Women's Aid
Bill Griffiths	Independent Chair and Author of report
Tony Hester	Independent Manager and Panel Secretary

AUTHOR OF THE OVERVIEW REPORT

20. Bill Griffiths is the author of the overview report. He is a former police officer who last had operational involvement in LB Southwark in 1993. He has been appointed as the independent Chair of the DHR Panel having had no involvement in policing since retirement from service in 2010. Set out for reference in appendix 2 are the full respective backgrounds and 'independence statements' for Bill Griffiths and Tony Hester who managed the review process and liaison with the CSP and Panel. Since 2013, they jointly have been involved in more than twenty DHRs. The Panel were satisfied as to the independence of the authors of IMRs that were woven into the overview.

PARALLEL REVIEWS

21. The police Investigating Officer has briefed the Panel and provided access to family liaison. The LAS declared a Serious Incident (SI) and conducted an internal investigation. As a result, one Call Handler from the SE London 111 Contact Centre was required to attend a feedback and reflection session and attend further training.

22. The Coroner opened the Inquests and adjourned them to 7 October 2019 when the Case Officer presented an investigation report. The Coroner's decision was that Barbara Hubert had been assaulted and unlawfully killed having been pushed out of the window of an 8th floor flat by Adam Smith who then died by suicide by jumping from the window, intending to take his own life. Third party involvement has been ruled out because the flat was strongly secured from the inside.

23. Due to an allegation of Child Sexual Abuse (CSA) by Adam against his daughter, Marie aged 13, the Local Children's Safeguarding Partnership for LB Bexley were invited to consider a joint Serious Case Review (SCR) and decided that it was not required. In this context, there was engagement with Marie's school and there was nothing recorded about her CSA allegation, nor any concerns about her safety or wellbeing.

EQUALITY AND DIVERSITY

24. Consideration has been given to the nine protected characteristics under the Equality Act in evaluating the various services provided:
    Age – Barbara and Adam were each 33 at the time of the fatal incident
    Disability – Adam had a history of mental illness, therefore, may have been an adult with care and support needs. The Panel discussed whether he met the Care Act threshold and agreed that he did not
    Gender reassignment – neither party had been, nor were known to be considering, gender reassignment
    Marriage and civil partnership – their relationship had been intimate but they were not married or in a civil partnership
    Pregnancy and maternity – did not have children and was not pregnant
    Race – Barbara was White Eastern European and Adam was black African Caribbean
    Religion or belief –there is no information either were practising religion or belief
    Sex – Barbara was female and Adam was male. Records show that the majority (74%) of victims of domestic homicide were female and that 80% of that number were killed by a partner or ex-partner[2]
    Sexual orientation – the sexual orientation for each is believed to have been heterosexual

25. The Panel have discussed whether there is evidence of differential service or 'conscious/unconscious bias' from any public body for anyone subject of this report. There is nothing obvious, but stereotypical assumptions regarding Barbara's Eastern European

[2] Office for National Statistics, Homicide in England and Wales - year ending March 2018, www.ons.gov.uk

origin or Adam's African Caribbean heritage cannot be ruled out. The intersectionality of the applicable protected characteristics will be explored in the context of the report.

DISSEMINATION

26. The intended recipients of copies of this report, once approved by the Home Office Quality Assurance Panel, are listed at the end of the review after the glossary.

BACKGROUND INFORMATION (THE FACTS)

Barbara Hubert

27. Barbara was born and raised in Bratislava, Slovakia from 1985 with an elder brother. She did well at school in both academic and sporting attainment, playing representative basketball to a high level. Aged 18, she enrolled on a sports degree course but had always wanted to study law so switched to that in the second year. This required a long commute and the serious relationship she had been in with a fellow pupil ended. She was raised in the Catholic faith and was a regular churchgoer when young. She did not drink alcohol or take drugs.

28. In 2006, she and a friend decided to visit London to improve their English and, through an EU project, she was enrolled on a media communications course in Croydon. She studied for five years living in rented accommodation, with her parents supporting her financially while she also found part-time employment as a shop assistant. On completion of her studies she found full time work in hospitality. Eventually, her parents purchased a two-bedroom flat for her but the maintenance fees were high so they sold it and, in 2016, purchased an eighth floor two-bedroom flat in Southwark that became the scene of the homicide. Barbara did not have a mortgage to pay and shared expenses for the upkeep of the flat with a friend, Nazia, living in.

29. Barbara was very open with her parents and they spoke by telephone or videocall at least twice a week. They visited her in the UK twice a year. If she needed money, she knew she only had to ask for it. She seemed to them not to have any problem with drugs or alcohol and was always healthy and full of life.

30. Her first boyfriend in the UK lasted a few years until he joined the army and it ended. She then met 'Clive' who had a young daughter and they would take her out for the day. They gained the impression she was fonder of the daughter than the boyfriend. The relationship ended in March 2018 but Barbara did not seem particularly sad about it. Nora's understanding of the breakup was that Barbara was interested in having a child and Clive was not. Nonetheless, she maintained a positive relationship with him after the breakup, as she had done with all her 'Ex's'.

31. Barbara's friend Nora met her in 2009 through hotel receptionist work in London's West End; they 'clicked' immediately and became firm friends who would socialise together in a

group of 3/4 others and confide in each other. Barbara was good at her job, open and honest; someone who would "tell it as it is". She wanted eventually to be a lawyer. She was compassionate to others and was always looking for 'new causes' to support. Barbara was a loyal friend; funny, extrovert to the point of being "loud", saying people should accept her as she is.

32. Barbara was also looking to improve and stretch herself, so moved to another hotel as a guest relationship manager. Her last job was for a company that managed serviced apartments and her portfolio was all of Europe.

Adam Smith

33. What little is known about Adam's earlier life is revealed in the witness statement for the police investigation by his daughter, Marie aged 13, in which she relayed the stories he shared with her during her childhood. He also made some relevant disclosures to clinicians that are noted in medical records.

34. Adam was born in Barbados in 1985 and when aged about 10, emigrated with his mother to the UK. They settled in LB Southwark where he attended a local school. His mother soon met another man and they had a son together. Thereafter, Adam had a troubled relationship with his mother due to not feeling accepted by her. He felt like "the black sheep of the family". They were estranged in the months leading up to the fatal incident.

35. In a psychiatric assessment in September 2018, Adam disclosed he had an instance of minor superficial self-harm and an overdose attempt when aged 18 because he was wrongly arrested[3].

36. Adam had several jobs over the years and spoke fondly to Marie of being a DJ. He worked as a bingo caller, then a fast food chain in Paddington before the job he loved - working for a large supermarket chain, which he did for 5 years. As confirmed by his GP record, this came to an end in August 2007 when immigration officials interviewed him at work regarding a discrepancy with his passport. As a result, he was dismissed and fell into a spiral of depression, thinking he could be deported. This added to the tension with his mother because he believed she held back on the information needed to resolve the matter[4].

37. The GP Practice notes in 2007, record that Adam had an ongoing low mood over the immigration incident and openly expressed concern that his mood swings make him feel aggressive to others. He was screened for suicide ideation which he denied at the time but because of the effect of his circumstances on his mood he was given a 28-day MED3[5]

[3] The police have no record of Adam until the fatal incident
[4] In later medical notes Adam states that the problem was resolved and he has leave to remain in the UK
[5] The form on which clinicians certify that someone is unfit for work

certificate for "depression – to gather his thoughts". He was not seen at the Practice again until 2010.

38. Adam met Marie's mother Sarah in 2003 when he was selling DVDs in a market. They formed a relationship and Sarah gave birth to Marie when aged 15 in 2005. He was living in Southwark at the time but moved in with Sarah's family in LB Bexley. After a year, he separated from them but maintained an interest and relationship with Marie.

39. Between March 2010 and September 2012, Adam was frequently seen at his local GP Practice for depression. He had been smoking cannabis and crack cocaine. He disclosed auditory hallucinations and scored 22/27 on the PHQ-9 depression questionnaire. He was prescribed anti-depressants and referred to the Community Mental Health Team (CMHT). In mid-September 2012 he mentioned problems regarding access to his 7-year old daughter (Marie) and scored high (20/27) for depression. During some of this period, Adam moved to another practice in LB Lewisham which may account for the fact that there was no mental health specialist input and that the referral to Southwark mental health services was then closed. He did attend his new practice to resume help with his mental health, but he did not receive any specialist input. Adam was also registered at a Practice in Leicester between 2013 and 2016. He was not seen again at his local Practice until 2017 and not for mental health issues until September 2018.

40. Adam was assessed by a psychiatric liaison nurse in the South Southwark Assessment and Liaison Service (part of the CHMT) in August 2010. He presented with biological symptoms of depression and reported negative thoughts and command hallucinations telling him to kill himself but confirmed no intention to act on them. There was a disconnect between the disturbing thoughts and his calm presentation. The diagnosis was unclear and complicated by the fact he confirmed regular cannabis use, including skunk. The nurse arranged for him to be seen by the Consultant Psychiatrist but this was cancelled because he had moved to Lewisham.

41. Adam is known to have had a number of other relationships. After breaking up with Sarah, he met Helen via a dating website. She lived in Cardiff and in the course of an on/off relationship, they had a son, Child B in 2012. He then met and lived with Jane in Leicester for about two years before returning to Helen to live in Wales.

42. In November 2015, Sarah died suddenly and unexpectedly due to a blood clot. Subsequently, Adam "upped his game"[6], moved from Wales back to London to give more of his time to Marie, rented a flat nearby for which he gave her a key and purchased a modern mobile telephone so that she could contact him, for which he paid the bills.

43. Marie recalls that Adam had taken her to visit Jane in Leicester for Halloween when she was about 11 (2016). Jane had a daughter about the same age as her. She also

[6] Source: Rose the MGM

remembers September 2018 when Rose was on holiday and Adam picked her up "out of the blue" to take her to Cardiff to see her half-brother, Child B.

44. In September 2016, Adam gained employment with an IT service company as a Field Engineer. This role involved travel to locations where his skills were required, including France and Germany. A work colleague named Jim befriended Adam and invited him to his home to share Christmas. He considered Adam to be a "gentle and quiet person", who might occasionally kick the tyre of the van or bang the steering wheel if things went wrong but he was not prone to violence.

45. Rae regards Adam as her brother-in-law because of his relationship with her sister Sarah and also as her 'big brother'. He was a "gentle giant" of a man, very intelligent, very kind to others and not aggressive. He was a good father to Marie and role model for her two half-brothers who called him "Daddy Adam". In March 2018, Rae consoled Adam when he broke down in tears over the question why his mother did not love him.

Timeline of their relationship and contact with agencies[7]

June 2018

46. In June, Barbara met Adam via a dating website. Barbara told Nora that when Adam first walked in her flat he said: "I'm not going anywhere". She added that she interpreted that to mean he was a serious man who wanted a serious relationship. Friends were surprised that Adam had moved in within 4 days of his first visit. Barbara sent his photograph to her parents and Susane was concerned at his physical size (190cm and stocky), enquiring if Barbara felt safe around him. Barbara reassured her mother. Nora was not concerned about this because Barbara was "proportionate" to Adam in size and weight.

47. Barbara also disclosed that Adam was not an outgoing type and did not enjoy being in the company of others. This was noticed by Barbara's friends. Nora had met Adam at a number of social gatherings with friends and she cannot recall an occasion when he spoke. Nora gained the impression that Adam was depressed for most of the relationship. He would go quiet and Barbara would say he was: "in one of his moods again".

48. While there was never any suggestion that he was violent toward her, Barbara did explain to her friends that Adam "masturbates a lot". This was initially treated as a joke but when Nora met Adam at her home for the first time, she heard Barbara say to him: "Don't embarrass me in front of my friends". Nora's understanding of the reason that Barbara's flat-mate Nazia left in September was connected with this apparent compulsion. The disclosure to Barbara's friends is relevant to this review because the compulsion later manifest in the child sexual abuse (CSA) of Marie that, in turn, became a critical issue on the day of the fatal incident.

[7] This narrative is also interspersed with input from friends and family to enhance continuity

49. Nora was also aware of other possible mental health issues with respect to Adam. For example, Barbara described Adam experiencing a panic attack when they went shopping in a large supermarket. Another friend had observed that Adam was at the flat sitting down with a vacant expression and his nose was copiously running into his mouth without reaction from him until Barbara told him to attend to it.

50. In mid-June, Barbara attended the different Southwark Practice where she was registered complaining of acute shoulder pain for which she was given painkillers. The next morning at 08:28, following an emergency call, the LAS attended Barbara at her flat in Southwark. She was hyperventilating due to pain in her left arm and chest. She was in bed and explained that she had slept awkwardly. She was given pain relief and conveyed to the care of KCH. The records there show that Barbara was assessed for what is coded on the accident and emergency discharge letter as "bruised shoulder"[8] and discharged back to her GP. The notes themselves have been checked and there was no record of any visible bruising to the skin on the shoulder, and no suspicion about the reported mode of injury. An X-Ray of the pain area was reported as 'normal'.

51. Barbara did sustain an injury to her back and neck as the result of a motorway traffic collision in August 2015 and this may have been the underpinning cause. However, Nora described from her perspective the onset of this acute condition in June 2018 as "sudden" and she did ask Barbara whether it involved Adam. Barbara's mother had asked her directly whether the injury had been caused in strange or unusual movements while making love. Barbara laughed off both enquiries.

52. About 10 days later in June, Barbara attended her GP still with the shoulder pain for which she was prescribed Naproxen and, subsequently, Amitriptyline for pain relief. She was given a MED3 for two weeks. This problem continued on and off until October.

<u>July</u>

53. At 04:45 one morning in early July, the LAS attended Barbara for a trapped nerve in her back that had caused vomiting. Barbara was able to answer the door and relayed the 3-week history with the pain worsening. She was assessed, given pain relief and conveyed to KCH. Barbara was assessed with back pain and discharged to her GP. The next day her GP issued a MED3 for two weeks and referred her for a second time to the musculoskeletal clinic. At her appointment after three weeks, the symptoms had improved, she had returned to work and started swimming.

54. On a day in July, Adam took Marie to stay the night with his friend Kate. Later (likely in September) Adam confided that Kate was pregnant with his child and they had met via a dating website. Adam disclosed to Marie he was worried about Barbara's reaction as she was not aware of his relationship with Kate or that he had another child (B) with Helen.

[8] The reference to bruising appears to have been selected from a limited list of options for the hospital coding system and may have been the closest 'read code' even when bruising was not seen by the clinician

55. At some point in July it is understood that the relationship between Adam and his mother broke down completely and they became estranged. This is likely to be connected to the occasion in March when he was consoled on this issue by Rae. It is relevant because the perceived rejection by his mother may have added to Adam's mental health pressures.

August

56. During August, Marie was on holiday in Europe with her extended family and would FaceTime Adam. She could tell that he was in Barbara's flat and she could be seen in the background.

September

57. At the beginning of September, Barbara's flat-mate Nazia moved out because she had a new job outside of London[9]. Adam told Marie, and Barbara mentioned to Nora, that the room would be prepared so that Marie could visit and stay there.

58. At 04:13 on a morning in early September, Barbara called NHS 111 to report that Adam had had been talking about suicide for a day and been refusing to eat which had been going on for a long time as if he was starving himself. An initial assessment was completed and Adam was passed to a clinician who established that there was "no worsening" of a known mental health problem, he had been behaving abnormally and had "smoked weed" the evening before. The clinician consulted the "tox-base" system and the recommended response was an emergency treatment centre referral within one hour.

59. At 05:22, Adam attended KCH Emergency Department (ED) with Barbara, reporting a low mood. Barbara had brought him there after he reported feeling "empty and doesn't want to be living any more". He was assessed by a by a member of the psychiatric liaison team in A&E over two hours and extensive notes recorded of his history with a full risk assessment completed. It is noted that Adam denied psychotic symptoms although his girlfriend reported that he sometimes is paranoid in that he thinks that their neighbours are talking about them; also, he sometimes thinks that people know that he is in his overdraft and how much he is owing[10].

60. Of the 14 evidence based risk factors that are known to increase a risk of suicide in individuals with depression, Adam had two historical risk indicators and two current. The historical risks included an act of self-harm and an attempted overdose before his first presentation in 2010. The two current risks identified were his substance misuse (reported outlay of £120 per week for 14g) and feelings of hopelessness. Adam also identified his children and his relationship with Barbara as protective factors. The impression gained was that he had: "mild depression and possible misuse of cannabis".

[9] This may be the case but Nora has the impression that it was because Nazia did not feel safe around Adam
[10] Adam reported two overdrafts of £1500 each

61. Adam was discharged from A&E back to his GP after he was assessed by the member of the psychiatric team as being at low risk of harm to himself and others. He was advised by psychiatric liaison to self-refer to Talking Therapy, which he agreed to, and Barbara was happy to take him home. He wanted to go to work that day. The GP surgery was contacted by the couple in the morning and an appointment was secured that same day with the Practice Psychiatric Nurse – a service that is not available in many other practices. Adam attended the appointment accompanied by Barbara. To the nurse he disclosed a low mood and: "feeling like the neighbours are talking about him".

62. The couple admitted they had both been smoking cannabis, but as Barbara had not experienced similar paranoid thoughts she expressed that she did not think that it could be the cannabis causing Adam's symptoms. This implies some misunderstanding of how drugs can affect individuals differently. The clinical notes have been checked and there was a plan to challenge the false assumption at a later meeting once trust had been developed. The referral was made to Talking Therapies and they were booked as a couple for further work with the nurse.

63. Two days later, Barbara attended the St Thomas Hospital (G&StTH) Musculoskeletal Clinic, having been referred by her GP with a 5-month[11] history of left-sided neck and arm pain into the fingers. The symptoms were noted to be consistent with prolonged desk based activity. An MRI scan was normal and Barbara was referred for physiotherapy. This is relevant because, when she informed her mother about the injury, Susane asked if the injury had been caused by Adam. Barbara reassured her that it was not.

64. In mid-September, Adam missed the pre-booked Talking Therapies telephone consultation and a letter was sent to advise that the referral would be closed. That day, Adam was seen with Barbara by the GP Registrar who noted the long term cannabis use and the previous overdose many years ago. Adam confirmed hearing voices but denied any command of self-harm or harm towards other people. The Registrar was sufficiently concerned that he referred Adam to specialist mental health services for a psychiatric opinion, specifically marking his referral as urgent, on the basis of possible psychotic symptoms (hallucinations and paranoid delusions) and history of a previous suicide attempt (in 2010).

65. Later that day, Adam emailed his employer to say he could not work, had to go to hospital and "will need to request some additional time off until further notice". He forwarded the two-week MED3 certificate he had been given by the GP for anxiety and depression.

66. Three days after that, Edward and Susane visited Barbara, met Adam for the first time and stayed for two weeks. They noticed that Adam remained in the flat the whole time. He cooked his own food and Barbara explained that he did not like Slovakian cuisine. On her return from work, she would ask him if he had eaten because she was concerned that he

[11] This is inconsistent with the GP record for this issue commencing in mid-June. The clinical note at G&StTH has been checked and the 5-month history was self-reported by Barbara

would go a whole day without eating. They noticed that she would always go to greet him; Adam never greeted Barbara.

67. Barbara had decorated her second bedroom as an office for Adam so that he could work from home. Her parents purchased a table from a furniture company for him and when Edward assembled it Adam showed no interest in helping him. The assembly was completed at 4pm and Adam then went to the room and did not reappear until the morning. When asked, Barbara explained that someone had called him about his daughter. Barbara arranged to drop her parents at Liverpool Street Station for their return journey at the end of their visit. It was 4am and the only time that Adam accompanied them. Susane felt that he was monitoring them and Barbara, as if trying to control the situation.

68. Two days before that, the GP Registrar referral was considered at a SLaM CMHT meeting of the South Southwark Assessment and Liaison Team (SSALT - comprising four staff, including a psychiatrist). A response to the GP referral in mid-September was not deemed to need secondary service input. The recommendation instead was that Adam considered reducing his cannabis use as a first step toward treatment and he could access support via Change Grow Live (CGL) an adult treatment centre for substance misuse. This would require another GP or self-referral and would be able to support Adam if he was motivated to attend and wanting to reduce his use of substances. The letter back to the GP also stated that if symptoms persisted after six months of abstinence from cannabis, the mental health team would then reconsider a new referral for onward therapy.

69. Three days later, Adam did not attend (DNA) for a mental health review with the Practice Psychiatric Nurse. This prompted her to try to contact Adam, but he did not answer his phone. She left a voice-message for him. A further follow-up call by the nurse after a week was not picked up either.

70. Adam's employer then emailed him to ask if he would be returning after the MED3 expired in late September. He responded that he was not fit enough to return but that he would send another 'sick note'. Adam attended the GP surgery in early October and saw a GP who backdated a MED3 that covered the period from late September to the end of October.

71. In late September, Barbara took a holiday in Mexico with a female friend for a week, returning in early October. Analysis of her telephone shows WhatsApp communication with Adam whereby she updates him on her travel progress. He tells her to have fun. She asks if he is alright and he responds that he has a bad headache. She urges him to drink fluids and to eat and that his body needs nutrients. He says his body is fine and she writes: "OK well starve ur self and then u will die. But that is what you want anyway". His response is that he is waiting but "not really". He concludes by telling her again to "have fun". Over the next two days, Barbara calls Adam multiple times and texts him to "please pick up or respond" but he does not.

72. Another significant event occurred sometime in the month of September, either before the school term or on a weekend because it involves Marie who was 13 at the time. This could

have been when Barbara was absent on the above holiday. Adam had a problem with excessive and compulsive masturbation, including in front of company. This had been discussed among Barbara's friends and with her. She said that Adam was trying to control the compulsion.

73. It is now known that he did the same to Marie. The first time was on the surprise trip to Cardiff which happened in this month. It was a 6-hour journey each way and they were in Cardiff for only 2 hours. Marie has described a period when her father was driving while: "scratching himself under his trouser for some time". She felt uncomfortable and made a comment at which he desisted. The end of the journey to London was Barbara's flat where he now lived. Adam warned Marie that there would be a smell of cannabis. She knew her father smoked cannabis and, as time went on, she saw his consumption increase.

74. Marie did not disclose this instance of CSA until after the fatal incident but the behaviour was repeated in October and it became an issue that Adam later obsessed about, leading to a crisis on the day of the fatal incident.

<u>October</u>

75. On a Sunday early in late September/early October, Jim answered the door after what seemed like an unnecessary length of ringing the bell, to unexpectedly see Adam there. He warmly welcomed him in but was surprised when Adam aggressively grabbed him by the shoulders and said: "You're part of that gang aren't you?" He went on to refer to the "[company they both worked for] gang" saying they had planted listening devices in the walls of his flat, adding that they had purchased the flat above so they could spy on him. Jim tried to reason and calm him but Adam walked out. Jim called him and Adam said that he just wanted to check he wasn't part of the gang.

76. Two days after returning from holiday in October, Barbara attended KCH reporting continuance of her back pain[12]. She was referred to physio outpatients but the appointment was set for mid-November, after her death. Two days after that, she had a telephone conversation with the Practice Nurse in which she explained this was lower back pain after her Mexico holiday. She saw her GP the next day and she was referred for another MRI scan.

77. That same day, Adam visited his GP Practice again because he needed a continuation MED3 for his employer. Adam saw a doctor who he had not consulted with before and was likely unaware of any recent response from the mental health team. The doctor noted that he was struggling with depression and asked him about thoughts of self-harm or suicide, which he denied. Adam also asked for help with neck pain, and said he was "not up for work" currently. A backdated MED3 for the the last week in September to the end of October was issued, together with advice to seek help from occupational health at his workplace and a referral for physiotherapy.

[12] This was not via the GP or LAS so may have been a 'walk in'

78. The day after that, Kate gave birth to Child C and it is not known if Barbara was aware. It is felt this is relevant to the review because of the added pressure on Adam's anxiety and depression diagnosis, which is not to minimise his responsibility for Barbara's murder.

79. In mid-October, Barbara lost her job due to the time off she was taking for her shoulder/back pain. She made it known she was not sorry to leave[13] and, within the following two weeks attended three job interviews.

80. Two days later, Adam emailed another company associated with his employer, offering his services as a 'developer' and asking to work from home. This was unprompted, and not relevant to anything that the companies do and not responded to by them.

81. Just after or around this time was the second incident of CSA by Adam of Marie. He was driving her somewhere and was smoking cannabis. He: "scratched himself again" and he stopped when she objected. He said he was not well and needed help and she told him he needed to seek help as soon as possible. From that point Marie refused to speak to her father but would not disclose the reason to Rose or Rae. When Rose asked Adam why Marie had stopped talking to him he said there had been a few obstacles in the relationship and he: "Feels like shit". He did not elaborate further. That this was a CSA incident was subsequently confirmed when Rae asked Marie to speak honestly about the incident and she said: "Yes, daddy was playing with his thing in the car".

82. Within a week of that incident, Adam called his work colleague and friend, Jim. Jim could sense anger in his voice when he said: "Look after your kids; make sure they do alright in life". Jim felt he was being criticised and politely ended the conversation. In hindsight he regrets that he did not engage with Adam and now sees the call as a possible farewell message.

83. Barbara randomly called on Nora over the weekend before the fatal incident, the last in October. They went shopping together for food and Nora noticed that Barbara carefully chose a piece of salmon to cook for Adam as he was very particular about how it would be cooked. She disclosed to Nora that she had been lent some money by a mutual friend and that she "hated being broke". Nora's view is that Barbara was in debt because of Adam; he paid nothing toward household bills and she paid for his telephone account.

84. The last telephone conversation that Nora had with Barbara was two days later when they spoke for about 20 minutes. Barbara was upbeat and very excited about her upcoming job interview.

[13] Verified by text messages on her phone and her LinkedIn profile

November

85. Early in November, Barbara's parents transferred £600 to her bank account because she had not received her final salary to the full amount. At some point that day, Barbara spoke to Nazia about the recent job interviews and she was "on a high".

86. At 19:32, Barbara sent a WhatsApp message to Adam: "I love you". He responded: "Hmm".

The day of the fatal incident

87. The next day at 10:43 Barbara sent a text to her parents that she had: "received the money OK x". At 11:46, she sent them a smile and a heart emoji. They later learned that Barbara had been contacted by one of her prospective employers from the three interviews that she would be offered a job on the following Monday.

88. On that day, Marie was at Rose's house and Adam had contacted her to say he would be calling to see her. She waited "hours" then decided to go out. Barbara arrived with Adam after she had left. This was the first time Barbara had been to the house and Rae gained the strong impression that she was desperately trying to help Adam. He was clearly agitated, repeatedly saying: "I fucked up" while pacing up and down.

89. Rae had a positive relationship with Adam and to calm him down, she took him to a nearby coffee shop. There he confessed that he had masturbated in front of Marie and that she had told him to stop which he did. He expected to be sent to prison and was inconsolable at the horror of what he had done to his daughter.

90. Rae has some experience of social work and she discussed with Barbara contacting the NHS 111 service for advice. She did so from the address of her paternal mother nearby at 15:51. An assessment was completed with the result that a known mental health problem had worsened; the individual was having suicidal thoughts but had not made a plan for a suicide attempt. The advice was to attend an emergency treatment centre within one hour.

91. Rae and Barbara exchanged telephone numbers and sent WhatsApp messages throughout the afternoon. Barbara and Adam set off to attend Queen Elizabeth Hospital (QEH) ED in nearby Woolwich. A police officer viewed the CCTV 3 weeks after the fatal incident and noted that they entered through the hospital main door arm-in-arm and Barbara spoke to the reception in A&E and there appeared to be a booking in procedure. They then sat together close to the exit without further interaction with staff until they left via the A&E exit, walking together to their car. The exact times of this footage was not noted.

92. At 17:31, Rae sent this message[14] to Barbara: *111 called they ask if you could call them for an assessment ASAP*. Barbara responded that she would do it now and Rae thanked her.

[14] All messages that follow shown verbatim as downloaded

93. The reason that Rae sent this message was because, after Barbara and Adam had left to attend the ED, she reflected on Adam's demeanour and became more concerned. By this time she had moved back to the home she shared with Rose, Marie and her half-brothers in Abbey Wood. She called NHS 111 again from the same mobile, related her concerns and asked to speak to a manager who then requested her to contact Barbara to call the NHS 111 service[15].

94. At 17:46, Barbara made a call to the NHS111 Service call. It was noted that Adam's depression had worsened and the Southwark address was provided. The 'instruction' provided again was to attend an emergency treatment centre within one hour. The call ended with the advice that if there were any new symptoms, or if his condition worsened or there were any other concerns to ring NHS 111 back again.

95. The nearest ED to the flat was KCH and it appears that Barbara and Adam set out to attend but did not make it. The following series of messages downloaded from Barbara's telephone supports that hypothesis:

18:26 Rae
How did you get on
18:46 Barbara
goign hospital now
19:10 Rae
Ok keep me posted
19:40 Barbara
we didn't get there…he start fighting with ne we nearly crashed…then I hv managed to call him down we back home…can't really talk…he really scared me… he said he need time…
19:41 Barbara
I can't push him…he will do something stupid
19:48 Rae
Oh no that's not good
He really needs to get to a professional
Did you call 111
19:50 Barbara
I can't now… I hardly got him home…I will try tomorrow…
19:50 Rae
What is he saying about it? Why won't he go
19:50 Barbara
I know je needs professionals but he don't want it
He don't want to talk to anyone…
I don't know je become very physical so I could stop him and drag him couldnt
19:53 Rae
That's not fair on you, you shouldn't be feeling that way, especially driving
Can you ask him to cal when he can
Call 999 if you need an ambulance they can also come out and assess him

[15] This contact has not been traced by the LAS who host NHS 111, London NE and SE (border with Kent)

96. Additional telephone information was provided to the Chair in the form of a WhatsApp printout. This does not have timings but appears to follow on directly from the earlier interaction.

Rae *I can imagine, that's not Ok. If he continues call the police or amubulamce they both have the powers to detain and assess*
Is he ok to he alone
Barbara *I don't wanna call police on him…*
I hope so
my door is open to hear him
Rae *I know but it's not for him being horrible or wanting to have him arrested or anything you can say it's for his own safety*

97. The family living in the flat below retired to bed at 21:00 and were woken by the sounds of a loud argument above them at about 23:30. There was then the unmistakable sound of a female screaming and a loud thud as her body hit the ground. Within two minutes another thud was heard. Police and paramedics were called a few minutes later and arrived to find Barbara and Adam fatally injured on the ground. Life was pronounced extinct at 00:36 the next morning.

The crime scene

98. The flat on the 8th floor of the block in Southwark was locked, bolted and chained from the inside and police had to force entry. Blood distribution in their bedroom indicated that Barbara had been assaulted in the room and had then been held with her head out of the open window for a short while before she fell. Hand marks around the window and bruising on her arms indicate that she was resisting, then forcibly tipped up and out of the window to her death by Adam who then pulled himself up through the window and jumped.

99. Displayed in a prominent position was a note handwritten in block capitals:

WE NEED TO HAVE A SERIOUS TALK ABOUT WHEN WE WAS DRIVING AND I INAPPROPRIATELY TOUCHED MYSELF IN FRONT OF YOU. IT WAS WRONG OF MYSELF AS AN ADULT AND THAT WONT BE HAPPENING AGAIN. I DON'T KNOW WHAT POSSESSED ME TO DO THAT, I'M WORKING ON GETTING HELP. NOTHING IS EXCUSING THE BEHAVIOUR FOR WHAT I DONE. CAN YOU FORGIVE ME. I AM SO SORRY

100. The note appears to be addressed to Marie and there is clear connection to the CSA incident. Given some references are to the future, it may be that this note was written in advance of the visit to her home with Barbara earlier that day when Marie had left before their arrival.

101. Both Barbara and Adam died from multiple injuries caused in the falls. Toxicology did not identify the presence of alcohol. THC, a chemical consistent with the recent use of cannabis was detected in both as well as a very low concentration of naproxen. Barbara had an additional reading for a low dose of amiltriptyline.

ANALYSIS

Overview

102. It is apparent that on the day of the fatal incident, Adam Smith was experiencing a mental health crisis over his prior inappropriate behaviour to his 13-year old daughter. Barbara was helping to resolve his inner conflict by taking him to meet Marie at her grandmother's home in order for him to apologise and seek forgiveness for what he had done. This intention can reasonably be assumed from the content of a written note left at the homicide scene. However, Marie had left to visit friends and the meeting did not take place.

103. Adam's anxiety increased and Rae, who had some experience of working with mental health, contacted the NHS111 service for advice which was to attend the local emergency department within an hour. Barbara and Adam attended Queen Elizabeth Hospital but did not stay for him to be assessed; instead they travelled home to Southwark. A third call[16] that afternoon to NHS111 by Barbara resulted in her driving Adam to Kings College Hospital, where he was known as a patient, but Adam violently resisted and they returned home.

104. From text messaging with Rae, it can be assumed that Barbara intended to try again the next morning, despite Adam's opposition. However, she expressed reluctance to follow Rae's advice to call police or ambulance if his behaviour continued as they would have powers to detain him for assessment[17]. Barbara's last message about Adam in response to Rae's query was that she hoped that he was "OK to be alone" and that "my door is open to hear him", with the inference that he had retired to his own room.

105. This was about four hours before Barbara's screams were heard, followed swiftly by the murder/suicide. It is not known at what point that evening (or quite possibly, before) that he decided to take Barbara's life, as well as his own, by pushing her from the 8th floor flat window, then jumping himself. Nor is it known whether she was aware of the intention and, if she became aware, whether she had the opportunity to leave the flat on her own volition. There is some evidence that Adam had experienced suicidal ideation and paranoia since early September, but none that he intended to murder Barbara.

106. The relationship between Barbara and Adam was relatively short-lived, less than six months, had developed rapidly and Adam had moved in within a few days of their meeting through a dating website. Barbara owned the flat and it is understood he did not pay her anything toward household bills. This must have affected her own financial assets as is implied by the fact she requested money from her parents a few days before she died. When her flat-mate moved out in September, Barbara converted the second bedroom to an office so that Adam could work from home, as well as a suitable place for Marie to visit and

[16] Rae made her second call to NHS111 and spoke to a supervisor but this has not been traced because the call went through to a 111 provider in a different area – not the London Ambulance Service that answered all the other calls
[17] Rae's opinion expressed in a text message but see also MHA section later in analysis

stay, yet he did nothing to support her effort. When her father purchased and built an item of flat-pack furniture he did not offer to assist him.

107. Adam exhibited introvert behaviours, for example, by retiring to his room when Barbara had visitors and he would prepare and cook his own food. When Barbara sent him messages of concern for his well-being from her holiday in July and an "I love you" message in November, his response was muted. When her parents visited for a week, he spent the whole time in the flat, except for the journey to take them to their return railway station. They noted that he never moved to greet her when they returned from a day out. Barbara's final message to Rae on the evening of the fatal incident intimated that Adam had gone to his room.

108. These behaviours may be construed as a version of control. For example, Nora observed that Barbara's innate extraversion and preference for socialising within their group of friends had been much reduced since her relationship with Adam. His compulsive masturbation habit that caused Barbara such concern and embarrassment was a form of sexual abuse. Adam also exploited her resources by failing to contribute anything to living expenses, running up debts of his own and causing her to be "broke" and calling on financial support from her parents. This may be seen as a version of financial control.

109. There is no evidence of physical abuse other than on the evening of the fatal incident when Barbara reported to Rae that, sometime between 18:46 and 19:40, Adam had fought with her in the car to resist attending Kings College Hospital for emergency assessment. Between June and October, Barbara had been treated for neck, shoulder and back pain, however, according to one medical report[18], the initial symptoms preceded her relationship with Adam. Nonetheless, taken longitudinally Barbara's recent medical history of acute neck/shoulder pain may have given cause for professional curiosity and 'routine enquiry' about domestic abuse.

110. Adam was mentally unwell. He had been treated for low mood, depression and experiencing auditory hallucinations and suicidal thoughts intermittently since 2007. He also reported cannabis and crack cocaine use that may have been related to his condition. Between 2010 and 2012 he was seen frequently at his local Practice and referred to the CHMT. His problems emerged again from early September 2018 through to the fatal incident and these will be examined from the three clinical perspectives that had contact with him and Barbara.

<u>Southwark CCG perspective regarding the Primary Care service</u>

111. It is likely that Adam's depression and possible psychosis, under the influence of cannabis, contributed to the deaths. Pyschosis is characterised by hallucinations, often auditory, that may sometimes tell you to do things you wouldn't normally want to do. These particular types of hallucinations are known as "command" hallucination, and sometimes

[18] Letter in mid-September 2018 from G&StH to Barbara's GP

goad individuals to harm themselves or others. Paranoid thoughts are also a feature of psychosis and can be caused by a primary mental health condition, or can be triggered by recreational drugs, such as cannabis. There is a complex interplay between substance use and mental health problems.

112. In the consultations at his medical practice in early September, Adam was becoming paranoid and reported hearing voices. On the day of the fatal incident, Barbara was trying to access urgent medical services for Adam because she was concerned that he was suicidal. This provides some proof that Adam's mental state was unstable on that day and that he was quite possibly psychotic.

113. Why was his depression and psychosis untreated?
Between 2007 and 2017, there are gaps in Adam's GP records as he moved around the country, in particular there was a missed opportunity due to this in 2010. He was also noted to be homeless on occasions. Within the clinical records for the September/October preceding the fatal incident, four reasons have been identified.

114. A) Difficulties accessing specialist Mental Health assessment, treatment, and support from Secondary Care services in the months before

- After a 2 hour assessment in A&E Adam was only thought to be suffering from "mild depression and possible cannabis misuse" which meant that he did not meet the threshold for specialist psychiatric help and was advised to go back to his GP.
- The local Practice was able to offer Adam an appointment with an in-house mental health nurse in early September after he presented at A&E. The psychiatrically trained nurse was able to see him the same day in an appointment that would have been longer than a usual GP appointment. This is a service that goes above what is offered in many other GP surgeries, but is not able to replace specialist psychiatric services when it is needed. The appointment was offered promptly, and follow-up was arranged.
- The consultation made by the GP Registrar was particularly detailed and made a thorough assessment of Adam's mental state with a prompt referral to the CMHT for a specialist psychiatric opinion. He marked the letter as "SOON PLEASE" and detailed the reason for wanting an urgent assessment to be based on his psychotic symptoms. The letter included consultation records from his encounter and the consultation with the Mental Health Nurse that day, when cannabis use was documented.
- Two rejection letters were received for services Adam was referred to, both made before any direct assessment themselves. Talking Therapies Southwark informed Adam that after one failed attempt to call him they were "closing the referral" but that he could make contact to book another appointment. SSLAT advised after screening the GP referral that Adam was "not deemed to need secondary service input", instead offering support through CGL to reduce his cannabis use. The letter added: "If symptoms persist after at least a 6 month period of abstinence, we will be happy to receive a new referral to screen for onward therapy referral".

115. B) There are limited services to support a patient with "Dual Diagnosis" of substance misuse and psychosis
    - It is standard practice to ask a patient to stop using recreational drugs before considering treatment of psychiatric illness, as it is difficult to determine whether the psychotic symptoms are a transient effect of the drugs or caused by primary mental illness (or an enduring effect of drug-induced psychosis). Whatever the cause of psychosis, these symptoms can be very worrying for patients and can pose as much a risk to themselves and others whether induced by drugs or not. In some areas of the country there is access to "Dual Diagnosis" services, through community mental health teams, that recognise the real risks associated with these combined problems. This is not readily available in Southwark.
    - Approaching the CGL service for support requires motivation from the patient, and attendance at appointments, something that Adam had struggled to keep up with at times. It does not offer any home visits/treatment. An initial assessment would be made by a support worker, who is not psychiatrically trained, but if they were concerned about any psychiatric disturbance they do have trained psychiatrists in the team who could do a further assessment. The service is not set up for managing psychotic patients and the next step available to CGL would be a referral to CMHT.

116. C) As Adam was getting more unwell he did not engage in follow-up arranged by the practice
    - On two days in late September, Adam failed to attend the Practice for follow-up with the Mental Health Nurse. On both occasions the nurse left messages on his phone, trying to make contact with him. Adam eventually responded and attended in early October, to be seen by a GP. He appeared to have a different agenda that day, asking for an assessment of his neck pain and asking for a referral to physiotherapy.
    - Poor motivation is a common difficulty when people have mental health problems – depression in particular - and makes access to support more difficult.

117. D) Seeing a clinician who was unfamiliar with his previous history and background may have led to a missed opportunity to refer to CGL, but this may not have altered the course of events
    - When Adam attended the last appointment above, he was seen by a doctor who had not seen him previously. The notes outlined an assessment of his suicide risk but did not detail an assessment of features of psychosis, risk of harming others, or his current drug use. Although the letter from the CMHT regarding the CGL referral was filed, it appears likely that it was not seen by the doctor before the consultation, as there is no mention of this being discussed with Adam.
    - It is also clear from the notes that Adam had a different agenda that day. He asked for a referral to physiotherapy for neck pain, and felt unable to go to work, requiring a medical certificate. Within a 10-minute GP consultation slot it is unsurprising that a

more detailed mental health assessment was not made if the background which led to that consultation was not well understood.

118. Could more have been done to address Adam's cannabis use?
Barbara accompanied Adam at both September appointments, firstly with a mental health nurse, secondly with a GP Registrar. Unfortunately, the follow up work with the MH nurse was unattended. Having sewn the seed that cannabis might be connected to the paranoid thoughts, a deeper discussion about reducing or stopping the cannabis use had been planned by this nurse but was not achievable. The plan was a good approach, as the first step in breaking the addiction cycle is in recognising that it is a problem. However, in acknowledging that they enjoyed smoking cannabis together, both appeared to misunderstand what may be contributing to the severity of his symptoms [19].

South London and Maudsley NHS Trust perspective

119. Adam was first assessed by the South Southwark Assessment and Liaison Team (SSALT) having been referred by his GP in May 2010. He had been given a diagnosis of depression and was being treated with anti-depressant medication. Concerns were raised when Adam reported experiencing suicidal ideas and voices telling him to kill himself. In terms of diagnosis the picture was somewhat unclear and complicated by the fact that confirmed regular cannabis use, including skunk, crack cocaine and alcohol. His appointment to see the Psychiatrist was cancelled when he moved to Lewisham.

120. In early September 2018, following Barbara's early morning call to the LAS, Adam was assessed by a psychiatrist over a period of 2 hours. Out of the 14 evidenced based indicators that are known to increase a risk of suicide in individuals with depression, the two current risks identified were his substance misuse and feelings of hopelessness. Adam also identified his children and his relationship with Barbara as protective factors. No violence and/or aggression was elicited. The conclusion was thatAS presented a low risk to himself.

121. When assessed by both the psychiatrist on the that day and the GP Registrar about a week later, Adam denied experiencing command hallucinations or having any intent or plans to harm himself and/or others. He confirmed he was having negative thoughts and was paranoid about a neighbour[20]. Adam confirmed to the GP Registrar that he heard voices of people he knew and people he didn't know but he did not know what the voices were saying. He had not made specific plans to harm himself or others.

122. It is not uncommon for people using a number of different substances to present with depressive symptoms as well as psychotic symptoms, which may be related to withdrawal from the substances or as the result of the substance that they have taken. These symptoms may be florid for the period they are under the influence of the substance but will

[19] This factual opinion should not be taken as a judgement or as 'victim blaming'
[20] Also mentioned to his friend Jim in early October

then subside and either be residual or disappear altogether once they reduce or abstain from use. Paranoia, auditory and visual hallucinations are common symptoms of cannabis and alcohol use, along with increased risk of impulsive self-harm and suicidal behaviour. It is difficult to mitigate against however, when an individual is unwilling to reduce their substance use.

123. It would not be ethical to prescribe anti-psychotic medication for anyone who does not have a diagnosed psychotic illness. There was no new information provided in the GP referral that would raise specific concerns or indicate a further assessment should be undertaken by SSALT. Adam had not taken up the talking therapy offered through the DMC and evidence demonstrates that psychological therapy can have poor outcomes for individuals with substance misuse difficulties. Psychological therapy can result in individuals with substance use difficulties increasing their use of substances as a means to coping with the difficult emotions being raised during the process. The screening decision was to refer Adam to CGL the adult treatment centre that supports individuals who are motivated to attend and to want to change their behaviour and reduce their use of substances. This was consistent with extant policy regarding 'Care and Treatment of People with Dual Diagnosis' (co-existing mental health and substance misuse problems) that had been reviewed and updated by the Trust in August 2018.

<u>London Ambulance Service NHS Trust perspective</u>

124. The Trust has in place a safeguarding adult's policy and practice guidance. With respect to the attendances at the Southwark flat in mid-June and early July to Barbara and early September to Adam, the ambulance staff have documented no safeguarding concerns and procedures were consistent with extant guidance..

125. The Trust's SE London 111 Service declared a Serious Incident following the homicide/suicide and an investigation started, including the dispatch process and the clinical care provided in the two calls[21] to the service on the day of the fatal incident. Findings from that investigation conclude that the first call was handled to a high standard.

126. The second call handler assessed through the correct algorithmic pathway and, although there did not appear to have been an escalation in behaviour or deterioration in the patient since the 1st call, it fell below the required standard. There was insufficient probing of cues and although they had ascertained through routine questions that the patient was not a risk to others or immediate risk to self, the potential severity of the patient's presenting symptoms were not fully explored. The caller indicated that they would probably not meet the 'disposition'[22] timeframe of one hour. The call should have been escalated as a 'refusal of disposition' to a clinician for further assessment in line with the Trusts procedure for Management of Calls SOP (Standard Operating Procedure).

[21] The third call by Rae was not received by the SE London Service provided by the LAS
[22] Meaning in this context, compliance with the advice given

127. Given the specific concern raised by Barbara's father about the NHS111 response, the Panel arranged to listen to recordings of both calls at its fifth meeting in February 2020, with the LAS representative present to advise on NHS111 procedure. The Panel support the Serious Incident investigation conclusion that the first call was handled to a high standard. They also noted that when Rae asked about Adam voluntarily "sectioning"[23], the call handler correctly pointed out that this would require assessment by a doctor.

128. The second call is in two parts of 12 and 3 minutes duration. In part one, the connection to the earlier call is established and Barbara explained that the reason for not waiting for assessment at QEH was that Adam had been assessed at KCH three months earlier. Adam's symptoms had worsened over the last three days and he was not eating. Barbara wanted Adam to be seen by a psychiatrist to "take the next steps to make him better".

129. Having confirmed Barbara's location and relationship with Adam, the call handler spoke to him. Adam confirmed that he was "not good" and that his condition had worsened. In answer to a question, Adam said that QEH did not have him on their system. The call handler responded with an explanation of the ED process and that it was not an appointment system, at which point Adam ceased dialogue and Barbara described him as "very upset at the phone call".

130. The call continued with a question about Adam's worsening condition and Barbara described anxiety and depression. She added that she was not sure she should disclose but it was about "something really bad he has done" and that he needed to speak to a psychiatrist about that. The call handler went on to assess Adam's level of care returning to the algorithmic pathway heard in the first call. Adam's known mental health problem had worsened and he was hot to the touch. There was no risk of violence and he had not threatened to harm anyone else. He did not want to live but had not made a specific plan to end his life.

131. The call handler advised that Adam should attend the ED at KCH within one hour and established that Barbara would drive him there. Barbara was then put on hold in order for the call handler to contact the Mental Health Crisis Line[24]. It is not known whether the call handler made contact with the Crisis Line but Panel members familiar with the system felt it may not have been answered.

132. Part two of the call does not make reference to the Crisis Line but begins with the call handler informing Barbara that the "clinical lead" had been consulted and reiterated the advice to attend the ED at KCH. When Barbara said this would be later on as they needed to get something to eat and that what she had to cook would take 45 minutes, the call handler stressed that they should attend within one hour and to mention the NHS111 advice to attend for "mental health crisis intervention". Should the condition worsen, they should call back for further advice. Having listened carefully and discussed the professionalism in the voice recordings in the second call, the Panel agree with the finding of the Serious Incident investigation that there was insufficient probing of cues and the

[23] An informal expression to describe admission to hospital under the Mental Health Act 1983
[24] A telephone number available to professionals to provide to patients – not generally available to the public

potential severity of the patient's presenting symptoms were not fully explored. Despite this misgiving, the advice to attend A&E within one hour was appropriate given the information available to the call handler.

133. The Panel further supports the investigation conclusion that it is not known whether with further probing a higher outcome, such as an ambulance attendance, may have been more appropriate or a better outcome may have been achieved by passing the caller to a clinician. The Panel noted the clinical opinion provided by the Trust's Mental Health Lead suggesting that, due to there being no evidence of acute concerns for the patient's mental health or potential risk of suicide, the management of the patient appropriately focussed on the presenting symptoms.

134. On reading the third version of this report, Edward has expressed surprise at how badly the critical situation was handled. He reasons: in a critical situation, one should not wait for the situation to deteriorate into an unmanageable state. The information provided by Barbara in that call was alarming and should have prompted the dispatch of an ambulance to the scene. He added the rhetorical question: "Were they waiting for Adam's statement that he would also kill Barbara?"

135. Mental health professionals on the Panel further noted that the algorithmic pathway may benefit from revision, for example, to assess whether inviting the caller to touch the chest of the patient is appropriate and necessary in mental health situations.

<u>Relevant powers under the Mental Health Act (MHA)</u>

136. The option of calling of an ambulance to Barbara's home, as highlighted by Edward, would have been the 'higher outcome' referred to in the LAS review above. The Mental Health Act 1983 provides the powers to police, health and social care practitioners so that they may seek and provide appropriate assessment and treatment of those suffering from a mental disorder.

137. Admission and treatment of people who are mentally disordered at hospital is usually initiated by an Approved Mental Health Professional (AMHP). It is the AMHP's responsibility in the first instance to explore whether alternatives to hospital admission would be sufficient to care for someone. When this is not possible, an AMPH may make arrangement under s2 MHA for someone to be admitted to hospital for up to 28 days in the interests of their own health or safety, or the protection of other people.

138. The AMHP assessment must be supported by two registered medical practitioners (doctors), one of whom must be approved under s12 MHA with specialist training and experience of patients with a mental disorder (usually a psychiatrist). The AMPH has a duty to consult the individual's 'nearest relative'. That person may make the section 2 application themselves.

139. While it is incorrect to assume that police and paramedics have the power to section anyone, paramedics are trained in mental health and could initiate the procedure to generate an AMHP assessment if invited in the home. Police have protective powers if

mental disorder occurs in public and would take the person to a locally designated place of safety[25] for assessment. Unless invited onto private property, their powers to enter and detain are limited to a belief that life is imminently at risk.

140. Edward has highlighted in his response to the third draft that the initiative should not rest with the a mentally ill patient or the accompanying person. They cannot be expected to correctly estimate the situation. Professionals, whether clinical or police, must act even if it subsequently turns out to be an 'unnecessary' intervention.

Summary of stress on the relationship

141. There is substantive research[26] available that relationship-based homicides are rarely spontaneous and the "He just snapped" explanation which suggests an immediate proximal provocation is not supported. Schlesinger describes 'catathymic homicides' as occurring when:

> *There is a change in thinking whereby the offender comes to believe that he can resolve his inner conflict by committing an act of extreme violence against someone to whom he feels emotionally bonded*

142. It has already been advanced that Adam was experiencing what might be termed a 'crisis of unresolved remorse' following his recent sexual abuse of Marie. Barbara was clearly trying to help him through it by driving him to meet Marie and staying with him through his increased anxiety when Marie was not available, twice attempting to find him psychiatric help on the day. She may well have suggested, or helped him to draft, the apology note found at the scene as part of resolving his remorse and search for forgiveness.

143. There is significant evidence available of Adam's worsening mental ill health and suicide ideation; but none that he had decided (or, in his mind, "had been commanded") to murder Barbara. Therefore, it may aid understanding to consider the other factors that had a bearing on their relationship:

1. The difficult relationship with his mother and the recent breakdown that, given his disclosure to Rae, felt like rejection
2. Not being able to work due to his breakdown on 3 September and the fear of losing his job
3. The running up of debts that may have been due to their joint cannabis consumption
4. The loss of Barbara's job and revenue, albeit that she had good reason to believe she had been successful in her recent interview and could probably depend on support from her parents until her new salary was paid
5. In October, visiting Jim in a threatening and paranoid disclosure that his friend Jim was seen by Adam as part of their employer's "gang" conducting surveillance on him
6. Also in October, the birth of his Child C
7. Added to which, Barbara may not have been aware of Child B or C

[25] As defined in s83 Mental Health Act
[26] Schlesinger 2002, Adams 2007, Monckton-Smith 2012

144. It should be added here that, in the professional experience of the mental health practitioner advising the Panel, there is a common misconception that a mental health condition (in Adam's case anxiety and depression) can lead to domestic abuse. The reality is that a mental health condition does not increase the *likelihood* of domestic abuse, but it can increase the *severity* of it.

CONCLUSIONS AND LESSONS LEARNED

145. One of the operating principles for this review is to avoid the biases associated with hindsight and outcome. There is no evidence available that the murder of Barbara by Adam was foreseeable by anyone in safeguarding. As for predicting his suicide, Adam had a known history of depression and suicide ideation prior to their relationship, with cannabis use as a factor. Over the five months of their relationship, certainly from early September, his depression seemed more acute with paranoia a feature, probably influenced by his use of recreational drugs. When asked, he did not report that he had formulated a plan to enact the suicide; there was denial of an intention to harm others.

146. The problems for clinicians when presented with Adam's symptoms in September were the difficulty in accessing Secondary Care services, the absence of treatment for the 'Dual Diagnosis' of substance misuse and psychosis and the lack of engagement by the person presenting. In Adam's case, he was not assessed to be sufficiently at the threshold for secondary care. Mild depression was identified by the last psychiatrist who assessed him and primary care treat many people with depression who are also using substances. At the time of his death, Adam was not open to SLaM as a patient.

147. The information not known to anyone in health was that Adam had a compulsive masturbation habit that he had twice exhibited to his daughter. The second occasion about two weeks prior to the fatal incident had resulted in Marie refusing to speak to him. Adam's intention on the day of the fatal incident, to make amends for his behaviour to Marie by meeting her to apologise, is verified by the note left prominently at the homicide scene. They did not meet; Adam was devastated and his reaction caused sufficient concern for Rae to contact NHS111.

148. In the call to NHS111 by Barbara, she does make reference to the reason for Adam's mental health crisis and the need to see a psychiatrist as "something bad he had done" but, understandably, she did not elaborate further. While this may be viewed as one of the cues that were not sufficiently probed or explored by the call handler at the time, it is not possible or appropriate to speculate on a different outcome from further questioning.

149. It has not been possible to trace a record of the second call made by Rae when she asked to speak to a supervisor in the NHS111 Service. There is no doubt that she made a call; the framing of her text message asking Barbara to call them is unambiguous. It seems that Rae's call was routed to another contact centre, not the one operated by the LAS. Enquiries with nearby health authorities have not found the record. Had the second call

handler been able to see on the screen that a supervisor had become involved since the first call was made, there may have been a different response to Barbara's call.

150. Another unknown is precisely the sequence of events in the flat between the hours of approximately 19:30 when Barbara and Adam had returned after the abortive visit to KCH and 23:30 when their lives were ended by his actions. Barbara makes reference in her last message to Rae that her door was open and she could hear Adam, which implies that she may have had some freedom of movement at the beginning of their last time together. At some point near the end, it is known that she was assaulted before being pushed through the window and that Adam had left the apology note to Marie in a prominent position to be found.

151. Having been cited as a "protective factor" in the risk assessment of Adam's suicidal intention, the possibility that Barbara was assaulted whilst trying to prevent him from dying by suicide in this way cannot be ruled out. However, such an hypothesis is highly unlikely because Adam was sufficiently powerful to resist any attempt by Barbara to prevent him jumping by simply pushing her aside. On the balance of probabilities it is felt that Adam's predictable journey to suicide had become inextricably linked with a decision also to murder Barbara.

152. A recent study[27] of Intimate Partner Femicide (IPF) uses Foucauldian analysis to track the eight stages that were present in almost all the relationships' progression to homicide. To conclude the analysis for this review, evidence from its narrative will be compared to the research findings.

Stage one: Pre-relationship history of stalking or abuse by the perpetrator

It is known that Adam had multiple relationships prior to meeting Barbara. He had three children with different partners. His relationship with Sarah, mother of Marie, is the only one with an insight available from her family and it did not last. However, when Sarah died, Adam did take on some of the parenting responsibility. There is no evidence of prior partner stalking or abuse available to this review.

Stage two: The romance developing quickly into a serious relationship

Adam and Barbara met through a dating website and friends and family were surprised that Adam had moved in within four days. His statement on first visiting her flat: "I'm not going anywhere", perhaps heralded a controlling approach but Barbara interpreted this as serious commitment on his part.

Stage three: The relationship becoming dominated by coercive control

The main elements of control by Adam were: psychological – his mental health and well-being dominated their relationship while he showed no concern for her, for example, when she was suffering with a shoulder injury and when she lost her job; sexual – his compulsive masturbation habit was a form of abuse; financial – he lived off Barbara's resources and contributed nothing from his; Barbara had to borrow money from her parents near the end; emotional – she made all the effort while he gave none and he was known for his moodiness, reclusiveness and absence of communication.

[27] Monckton-Smith 2019

Stage four: A trigger to threaten the perpetrator's control

It is generally recognised that separation leading to loss of control is a time of heightened risk. While there is no evidence that Barbara was planning to separate, it is felt that the trigger in this review was Adam's sexual conduct toward his daughter and that she had rejected him on the second occasion, which led to his frantic need on the day of the fatal incident to make amends being frustrated when they did not meet up.

Stage five: Escalation - increase in the intensity or frequency of the partner's control tactics

If Marie's rejection was the trigger, it is not known to what extent Adam would have lost hope, for example, by voicing that he expected imprisonment for the abuse, thus possibly intensifying his vision of suicide as the only way to reconcile his despair.

Stage six: A change in thinking/decision to act

The change that can be surmised from Adam's known behaviour is that he violently resisted Barbara taking him to KCH where he may well have been assessed by a psychiatrist and detained for treatment under the Mental Health Act. As a result, she was forced to return to the flat. It is possible that Barbara was no longer a protective factor but had, in Adam's mind, become an obstruction preventing him from completing his journey to suicide.

Stage seven: Planning

In the three hours available, sitting alone to ponder, it is feasible that Adam developed his plan to kill them both in the manner that he did. The display of the note to be found suggests an element of preparation.

Stage eight: Homicide

The research suggests, as is found in this review, it is not unusual for the extreme level of violence to appear to have no direct relation to the level of violence evidenced earlier in the relationship.

153. Finally, it is acknowledged that much of this review has been focused on Adam and his story. This imbalance is caused partly by the disproportionate amount of information available to the review through his greater inaction with agencies, but it also reflects Barabara's kind and caring personality. It is obvious that she cared deeply for Adam and may not have recognised his behaviour as abusive. For example, she welcomed him into her home without recompence and, latterly, was clearly supporting him financially. When her friend pointed out the abusive nature of his masturbation habit, she played it down and made excuses for his "moodiness". She knew about his CSA of Marie and was probably helping him to deal with his conflict of guilt on the day of the fatal incident.

154. Barbara had lived in London for 12 years and had an excellent command of English. She had close English friends and was open with them and her parents about her relationship with Adam. If she had recognised the elements of his abuse, it is not known if she felt constrained, or there were barriers in reporting it or otherwise seeking help.

RECOMMENDATIONS

155. IMR authors have made recommendations for learning from this homicide/suicide for their respective service and there are some for wider consideration. Internal recommendations have been made by Southwark CCG, SLaM and the LAS, some of which have already been implemented. These six recommendations have been consolidated in appendix 3 to this report, reviewed by the Panel and progress is satisfactory.

156. The IMR author for Southwark CCG made these recommendations for wider consideration:
    1. SLaM to outline their recommended approach for GPs for dealing with psychotic patients who also have a substance misuse problem, to guide GPs to refer to the most appropriate services. This could be disseminated electronically but could also be included in the Protected Learning Event (recommendation 1 appendix 3)
    2. Southwark CCG/SLaM to explore existing services, to identify gaps in managing patients with dual diagnosis where there are substance misuse issues and worrying psychiatric symptoms, and to consider how any identified gaps can be addressed.

157. Similarly, the IMR author for SLaM made recommendations for wider consideration:
    1. All assessments of mental health will routinely ask questions about domestic abuse.
    2. Information on local domestic abuse support services are prominently displayed within clinical areas and non-clinical areas (toilets).
    3. All services when assessing mental health should routinely ask about domestic abuse and have information on local services visible and easily accessible.
    4. If during an assessment any concerns are identified in the dynamics of a relationship between two people, whether partners or relatives, individuals should where possible, be seen separately and asked about domestic abuse.

158. Taking these recommendations into account and robust discussion on the wider implications from the findings of this review, the Panel have identified the main strategic learning points:
    1. Greater awareness is required by front-line professionals of the likelihood for the presence of mental health issues to increase the severity of domestic abuse
    2. The system for managing psychotic patients who also have a substance misuse problem should provide better guidance to primary care
    3. The NHS111 system should be able to link earlier calls about the same patient when received by another contact centre.

159. Taking these strategic learning points into account, the Panel has agreed the following recommendations that form the Action Plan in appendix 4:
    1. To identify and deliver an awareness programme for all front-line professionals that highlights the connection between mental health issues and domestic abuse
    2. To review the system for managing psychotic patients who also have a substance misuse problem in order to provide and promote better guidance to primary care

3. NHS England to review the NHS111 system to ensure that repeat calls about the same patient received in different contact centres are automatically linked.

Author

Bill Griffiths CBE BEM QPM

23 May 2021

Glossary

AMHP	Approved Mental Health Professional
CCG	Clinical Commissioning Group
CGL	Change Grow Live (adult integrated drug and alcohol treatment service)
cjsm	Criminal Justice Secure eMail
CMHT	Community Mental Health Team
CSA	Child Sexual Abuse
DA	Domestic Abuse
DNA	Did not appear
DHR	Domestic Homicide Review
GP	General Medical Practitioner
gsi	Government Secure Internet
G&StTH	Guy's and St Thomas' Hospital NHS Foundation Trust
IMR	Individual Management Review
IPF	Intimate Partner Femicide
KCH	Kings College Hospital NHS Foundation Trust
LAS	London Ambulance Service NHS Foundation Trust
LB	London Borough
MPS	Metropolitan Police Service
NHS	National Health Service
PHQ	Patient Health Questionnaire
pnn	Police National Network
SLaM	South London and Maudsley NHS Foundation Trust
SSALT	South Southwark Assessment and Liaison Team
THC	Tetrahydrocannabinol
ToR	Terms of Reference
VAWG	Violence Against Women and Girls

Name references used

Barbara	Victim (aged 33)
Edward	Barbara's father
Susane	Barbara's mother
Clive	Barbara's former partner
Adam	Perpetrator (aged 33), Barbara's partner. Died by suicide
Sarah	Adam's former partner (deceased)
Marie	Adam and Sarah's daughter (aged 13)
Rose	Sarah's mother and guardian to Marie
Rae	Sarah's sister and aunt of Marie
Helen	Adam's former partner (Cardiff) and mother of Child B (aged 6)
Jane	Adam's former girlfriend (Leicester)
Kate	Adam's girlfriend and mother of Child C (aged 3 weeks)
Nora	Friend and former work colleague of Barbara
Nazia	Barbara's flat-mate
Jim	Friend and work colleague of Adam

Domestic Violence Homicide Review Panel – LB Southwark CSP
'Barbara Hubert' murdered by 'Adam Smith' and both found dead in Southwark In November 2018

Distribution List

Name	Agency	Position/ Title
Eleanor Kelly	London Borough of Southwark	Chief Executive
Cllr Evelyn Akoto	LB Southwark	Councillor for Community Safety and Public Health
David Quirke-Thornton	LB Southwark	Strategic Director Children's and Adult Services
Hannah Edwards	LB Southwark	LBS Safeguarding Board
Dr Megan Morris	LB Southwark	CCG Named GP Adult Safeguarding
Florence Acquah	LB Southwark	CCG Lead Nurse Adult Safeguarding
Sam Hepplewhite	LB Southwark	Place-Based Director (Southwark), NHS SEL CCG
Cheryl Russell	LB Southwark	Director of Residents Services
Heather Payne	Kings College Hospital NHS Trust	Adult Safeguarding
David Lynch	South London and Maudsley NHS Trust	Safeguarding Adults/Prevent Lead
Amy Glover	Solace Women's Aid	Independent Domestic Abuse Advocate
Angela Middleton	NHS England	Patient Safety Projects Manager (London Region)
Colin Wingrove	Metropolitan Police	South Central BCU Commander
Dan Ivey	Metropolitan Police	Chair of Southwark Community Safety Partnership Board
Graeme Gwynn	Metropolitan Police	Detective Sergeant Specialist Crime Review Group
Bill Griffiths	Independent Chair	Independent Chair/Author of the Domestic Homicide Review
Tony Hester	Director Sancus Solutions Ltd	Independent Administrator and Panel Secretary
Quality Assurance Panel	Home Office	-
Cressida Dick	Metropolitan Police Service	Commissioner
Sophie Linden	Mayor's Office for Crime and Policing	Deputy Mayor
Baljit Ubhey	Crown Prosecution Service	London Chief Crown Prosecutor

Appendix 1

Terms of Reference for Review[28]

1. To identify the best method for obtaining and analysing relevant information, and over what period prior to the homicide to understand the most important issues to address in this review and ensure the learning from this specific homicide and surrounding circumstances is understood and systemic changes implemented. Whilst checking records, any other significant events or individuals that may help the review by providing information will be identified [Note: agreed on 20 March that chronologies would cover the period 1January 2010 to date of homicide]

2. To identify the agencies and professionals that should constitute this Panel and those that should submit chronologies and Individual Management Reviews (IMR) and agree a timescale for completion [Note: agreed on 20 March to review initial membership on receipt of chronology reports]

3. To understand and comply with the requirements of the criminal investigation, any misconduct investigation and the Inquest processes and identify any disclosure issues and how they shall be addressed, including arising from the publication of a report from this Panel [Note: there are no known criminal or misconduct proceedings but the investigation remains *sub judice* pending the Inquest]

4. To identify any relevant equality and diversity considerations arising from this case and, if so, what specialist advice or assistance may be required [Note: Barbara is female and White Eastern European and Adam is male and Black African Caribbean. In 2005,AS experienced an immigration review which may be relevant to his subsequent mental health condition]

5. To identify whether the victims or perpetrator were subject to a Multi-Agency Risk Assessment Conference (MARAC) and whether perpetrator was subject to Multi-Agency Public Protection Arrangements (MAPPA) or a Domestic Violence Perpetrator Programme (DVPP) and, if so, identify the terms of a Memorandum of Understanding with respect to disclosure of the minutes of meetings [Note: neither is known]

6. To determine whether this case meets the criteria for a Serious Case Review, as defined in Working Together to Safeguard the Child 2015, if so, how it could be best managed within this review [Note: Adam's three children are not directly involved in the fatal incident, but there is reference to sexual abuse by Adam of Marie]

7. To determine whether this case meets the criteria for an Adult Case Review, within the provisions of s44 Care Act 2014, if so, how it could be best managed within this review and whether either victim or perpetrator(s) were 'an adult with care and support needs' [Note: Adam not known to services but his mental health condition to be kept under review regarding his care and support needs]

8. To establish whether family, friends or colleagues want to participate in the review. If so, ascertain whether they were aware of any abusive behaviour to the victim prior to the homicide (any disclosure; not time limited). In relation to the family members, whether they were aware if any abuse and of any barriers experienced in reporting abuse, or best practice that facilitated reporting it [Note: Barbara had family in Slovakia. She had a close circle of friends who have

[28] Third version issued on 05/11/19

provided witness statements to the investigation. Adam's family were involved with Barbara in attempting to have his MH condition treated]

Statement by Edward Hubert at Southwark Coroner's Court on 7 October 2019
"Our daughter died when she wanted to help her friend. She died unnecessarily. She could do as her surroundings, indifferent, and she could still be alive. She looks for a help by professionals, professionals who have it as their duty, but unfortunately she met with an unprofessional and indifferent attitude and paid for it the highest price – with her life. When you read our daughters phone call records with emergency, you must see how silly the operator responded. There was a very serious problem, her friend wanted to kill himself, not a broken leg or increased temperature. She even managed to bring him to the hospital but they let them go, even our daughter called again that the condition was getting worse, but nothing happened. What do you think how should the operator act? In this case no manual or regulation was needed only normal human approach like: "Madam stay where you are, try to keep him calm, we have your phone and address don't worry we send the ambulance", yes so simple and both could be alive. I have another question. What for the questionnaires, which the daughter successfully completed two times served, altogether the hospital had three times completed questionnaire for this very serious case, only as a statistic or as basis for further progress, which in this case completely failed and absent! If the operator has acted in accordance with regulations (acting on the border of common sense) consider these regulations very quickly. This tragic case shows where indifference, alibism or "who cares" lead
Make it an exclamation point for you and ask yourself why nobody didn't give her a helping hand. Once again Why? I ask you can you sleep peacefully, because we her parents don't. Hardly ever to find peace in our soul."

9. To identify how the review should take account of previous lessons learned in the LB Southwark and from relevant agencies and professionals working in other Local Authority areas [Note: Ongoing]

10. To identify how people in the LB of Southwark gain access to advice on sexual and domestic abuse whether themselves subject of abuse or known to be happening to a friend, relative or work colleague [Note: Ongoing]

11. To keep these terms of reference under review to take advantage of any, as yet unidentified, sources of information or relevant individuals or organisations

Panel considerations

1. Could improvement in any of the following have led to a different outcome for Barbara Hubert and Adam Smith, considering:
   a) Communication and information sharing between services with regard to the safeguarding of adults and children
   b) Communication within services
   c) Communication and publicity to the general public and non-specialist services about the nature and prevalence of domestic abuse, and available local specialist services

2. Whether the work undertaken by services in this case are consistent with each organisation's:
   a) Professional standards
   b) Domestic abuse policy, procedures and protocols

3. The response of the relevant agencies to any referrals from 1 January 2010 relating to Barbara Hubert and Adam Smith. It will seek to understand what decisions were taken and what actions were or were not 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 with [insert names]
   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 any risk assessments undertaken by each agency in respect of Barbara Hubert and Adam Smith

4. Whether organisational thresholds for levels of intervention were set appropriately and/or applied correctly, in this case.

5. Whether practices by all agencies were sensitive to the ethnic, cultural, linguistic and religious identity of the respective individuals and whether any specialist needs on the part of the subjects were explored, shared appropriately and recorded.

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

7. Whether, any training or awareness raising requirements are identified to ensure a greater knowledge and understanding of domestic abuse processes and/or services.

8. Identify how the resulting information and report should be managed prior to publication with family and friends and after the publication in the media.

Operating Principles

a. The aim of this review is to identify and learn lessons as well as identify good practice so that future safeguarding services improve their systems and practice for increased safety of potential and actual victims of domestic abuse (as defined by the Government in 2015 – see below)

b. The aim is not to apportion blame to individuals or organisations, rather, it is to use the study of this case to provide a window on the system

c. A forensic and non-judgmental appraisal of the system will aid understanding of what happened, the context and contributory factors and what lessons may be learned

d. The review findings will be independent, objective, insightful and based on evidence while avoiding 'hindsight bias' and 'outcome bias' as influences

e. The review will be guided by humanity, compassion and empathy with the victim's 'voice' at the heart of the process.

f. It will take account of the protected characteristics listed in the Equality Act 2010

g. All material will be handled within Government Security Classifications at 'Official - Sensitive' level

Definition of Domestic Abuse

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

- psychological
- physical
- sexual
- financial
- emotional

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

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

Appendix 2

Independence statements

Chair of Panel

Bill Griffiths CBE BEM QPM was appointed by the London Borough of Southwark CSP as Independent Chair of a DHR Panel and is the author of the report. He is a former Metropolitan police officer with 38 years operational service and an additional five years as police staff in the role of Director of Leadership Development, retiring in March 2010. He served mainly as a detective in both specialist and generalist investigation roles at New Scotland Yard and in the Boroughs of Westminster, Greenwich, Southwark, Lambeth and Newham.

As a Deputy Assistant Commissioner, he implemented the Crime and Disorder Act for the MPS, leading to the Borough based policing model, and developed the critical incident response and homicide investigation changes arising from the Stephen Lawrence Inquiry. For the last five years of police service, as Director of Serious Crime Operations, he was responsible for the work of some 3000 operational detectives on all serious and specialist crime investigations and operations in London (except for terrorism) including homicide, armed robbery, kidnap, fraud and child abuse.

Bill has since set up his own company to provide consultancy, coaching and speaking services specialising in critical incident management, leadership development and strategic advice/review within the public sector.

During and since his MPS service he has had not had personal or operational involvement within the London Borough of Southwark (since 1993), nor direct management of any MPS employee (since 2010).

Secretary to Panel

Tony Hester has over 30 year's Metropolitan police experience in both Uniform and CID roles that involved Borough policing and Specialist Crime investigation in addition to major crime and critical incidents as a Senior Investigating Officer (SIO). This period included the management of murder and serious crime investigation.

Upon retirement in 2007, Tony entered the commercial sector as Director of Training for a large recruitment company. He now owns and manages an Investigations and Training company.

His involvement in this DVHR has been one of administration and support to the Independent Chair, his remit being to record the minutes of meetings and circulate documents securely as well as to act as the review liaison point for the Chair.

Other than through this and two other reviews, Tony has no personal or business relationship or direct management of anyone else involved.

Appendix 3

Consolidated internal recommendations from agency IMR's

Rec No	Agency/Source	Action taken or to be taken within agency	Outcome of action, what has been achieved and date of completion
1	Southwark CCG	*Reflective teaching around this case at Southwark-wide Primary Care Protected Learning Events on Safeguarding Adults.* This will : 1) Raise awareness of the need for primary care clinicians to screen for drug and alcohol use, psychotic symptoms, and risk of harm to others when making a mental health review. Primary care clinicians are good at screening for risk of suicide, but often fail to screen for other risks. It will highlight the importance of considering the social context of the individual, and who else may also be affected by the symptoms of their illness 2) Include the need to discuss and consider a referral to drug and alcohol rehab services early in an individual's presentation, so that specialist mental health services can later be accessed if necessary 3) Encourage professional curiosity, to be proactive in screening for domestic abuse, and to think to ask beyond what an individual first tells us	Protected Learning Event was held in November 2019 with a presentation from a psychiatrist who works for Change Grow Live about cannabis use and psychosis, highlighting the need for early referral and intervention. The event also discussed ways of screening for domestic abuse in short consultations, remaining always curious, and thinking beyond what the patient initially presents with. A further learning event is planned to build more on this, at a GP forum May 2020. Once multi-agency discussions have confirmed clear dual diagnosis treatment pathways this information can also be

		4) Showcase having psychiatrically trained nurses in practices to offer longer appointments, and therefore more in-depth assessments and interventions, as the local Medical Centre do	presented at a training event and disseminated electronically
2	South London and Maudsley NHS Foundation Trust (SLaM)	The link worker system will be regularly reviewed with the GP surgeries to ensure it is working effectively and any problems speedily addressed	Clinical Service Leads to confirm that the recent review of the link worker system has been undertaken By October 2020
3		It should be made clear in the link worker guidance provided to GP surgeries that if there are specific concerns about a referral, the GP should contact the link worker and/or a member of the CMHT when making the referral to discuss this further	Clinical Service Lead to confirm that guidance to GPs has been provided and ensure that the mechanism is in place to invite GPs to contact CHMT to discuss referrals By October 2020
4		Similarly, it should be made clear in the Link Worker guidance provided to GP surgeries that if a GP is concerned about a referral decision made by the CMHT they should contact the link worker and / or a member of the CMHT to discuss this further	Clinical Service Lead to confirm that there is a mechanism in place for GPs to discuss any concerns about the decision made by the CHMT By October 2020
5	London Ambulance Service	The Call Handler of the 2nd SE London 111 call must attend a feedback and reflection session on this call and attend further training on the management of refused dispositions	Recommendation completed February 2019
6		A case study should be shared with all staff with a reminder on the management of refused dispositions	Recommendation completed September 2019

Appendix 4

ACTION PLAN

Strategic learning point 1: Greater awareness is required by front-line professionals of the connection between mental health issues and domestic abuse						
Recommendation	**Scope of recommendation i.e. local or regional**	**Action to take**	**Lead Agency**	**Key milestones achieved in enacting recommendation**	**Target Date**	**Completion Date and Outcome**
1 To identify and deliver an awareness programme for all front-line professionals to raise the awareness of the connection between mental health issues and domestic abuse, so that there is an increased identification and thus increase in support to people affected by domestic abuse	Local	Southwark wide training to all GPs in collaboration with commissioned substance misuse service (CGL), to enable GPs to fully understand the interconnectivity between mental health, substance misuse and domestic abuse, and to be aware of the most appropriate form of intervention	Southwark CCG	Training delivered to in excess of 150 primary care professionals	Nov 2020	November 2020 - Increased confidence to ask more probing questions when reviewing patients with mental illness, to identify both victims and perpetrators of domestic abuse and then make appropriate referrals, in order to manage risk.

		Overarching review of current multi agency DA offer to ensure a mental health focus is incorporated	Southwark Safeguarding Adults Board	Review of training content updated to include a mental health focus	Nov 2020	Course promoted to partners and evaluation of impact monitored via the learning hub. More staff aware and better identification of cases – Ongoing.
				Domestic Abuse agreed as a partnership SSAB priority from 2020-21 and 2021-22.	March 2021	DA thematic review was undertaken for partnership assurance that key lessons have been embedded. Identified areas for further development, which have been translated into a further agency action plan – September 2021.
				Working with internal and external partners to mark International Day for the Elimination of Violence Against Women, and the 16 days of action that follow.	Nov 2020	In 2020 and 2021, workshops and information sharing sessions delivered throughout the 16 days of action, to raise awareness of the issue in the community, and support services available. To

						increase awareness of the support available to people affected by DA – Annually in November.
Strategic learning point 2: The system for managing psychotic patients who also have a substance misuse problem should provide better guidance to primary care						
2 To review the system for managing psychotic patients who also have a substance misuse problem in order to provide and promote better guidance to primary care	Local	CCG, SLaM dual diagnosis lead and other Southwark providers, to undertake a multi-agency scoping review to identify gaps in provision	Southwark CCG with South London and Maudsley Hospital Trust	Multi-agency review completed, gaps identified and action plan formulated.	Oct 2020	Ongoing - Joint working strengthened between SLaM and commissioned substance misuse provider through a service level agreement and monthly case management meetings, to ensure more robust mental health support for people with substance misuse.
		CCG and SLaM dual diagnosis lead to review pathway for patients with dual diagnosis and provide assurance that this is communicated to GPs		Review completed and changes communicated to primary care front-line professionals	Nov 2020	Ongoing – improved pathway from substance misuse service to mental health services, which has made access to mental health support for

						people with substance misuse more readily available. When a GP refers to substance misuse service they can be assured that mental health support will also be provided.
Strategic learning point 3: The NHS111 system should be able to link earlier calls about the same patient when received by another contact centre						
3 NHS England to review the NHS111 system to ensure that repeat calls about the same patient received in different contact centres are automatically linked	Local/ National	Robust review of NHS111 system to ensure appropriate information sharing	NHS 111 and NHS England	Southwark CCG to raise at the South East London 111 Quality and Safety Committee to explore ways of linking neighbouring NHS 111 systems Escalation to the NHS 111 Safeguarding Lead for it to be driven forward at a national level	July 2020	Ongoing – improved links between systems to enable identification of escalating risk.