



**Safer Sandwell
Partnership**

SAFER SANDWELL PARTNERSHIP

Executive Summary

Domestic Homicide Review of the Circumstances Concerning

Independent Chair and Author

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1: Introduction

- 1.1 The primary purpose of a Domestic Homicide Reviews (DHR) is to 'establish what lessons are to be learnt from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims'.¹
- 1.2 The requirement to undertake Reviews is part of the Domestic Violence, Crime and Victims Act 2004 and became law from 13th April 2011. These reviews are undertaken in accordance with guidance published by the Home Office and are chaired by an independent person. Reviews will not seek to lay blame but to consider what happened and what, if anything, could have been done differently. If appropriate, they will also recommend actions to improve responses to domestic violence situations in the future.
- 1.3 A Panel of professionals from various public bodies undertook this review, considering information provided by a number of organisations in the form of individual management reports (IMR). Reports were provided by: West Midlands Police; Sandwell and West Birmingham Clinical Commissioning Group (her G.P); Sandwell Council Neighbourhood Services; Sandwell and West Birmingham Hospitals Trust; The Black Country Partnership NHS Foundation Trust (Mental Health Services). Walsall Manor Hospital and Sandwell Council Adult Services also provided information reports. This panel has also assisted the Chair in formulating recommendations based on their conclusions and those of the individual report writers.
- 1.4 In order to retain the anonymity of those involved, the family members will be referred to within this report as follows:

Adult 1	Subject of this review
Adult 2	Perpetrator and son of Adult 1

2: Summary of facts

- 2.1 The circumstances leading to this review were:
- 2.2 Adult 1 died in October 2012. Police officers attended the address following an emergency call timed at 0126 hours from a male saying that he had killed someone. Officers discovered a male deceased on the pavement, who was a neighbour of Adult 1. Officers entered the address and found Adult 1 deceased in her bed with apparent stab wounds. Adult 2 then emerged from another flat and stated to officers that he had murdered them both and that Adult 1 was his mother. Further police investigations confirm that Adult 1 was killed first. He was arrested on suspicion of murder.

¹ Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews – April 2011: Section 3.3

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- 2.3 Following notification of this incident, the Community Safety Team collated information from partner agencies which suggested that neither Adult 1 nor Adult 2 were known to many agencies.
- 2.4 In December 2012, the Chair of the Safer Sandwell Partnership decided that the criteria for holding a Domestic Homicide Review was met in respect of Adult 1 and directed that such a review be carried out. As the neighbour was not a family member, and there was no evidence of any link between him and either Adult 1 or Adult 2, it was agreed that he would not be a subject within this Review. This was confirmed in subsequent reports.
- 2.5 Adult 2 was charged with the murder of his mother and of the neighbour. Following his arrest, Adult 2 was the subject of on-going assessment by both prosecution and defence expert witnesses in relation to his mental capacity.
- 2.6 In June 2013 it was agreed that he was fit to plead and was subsequently found guilty of the manslaughter of his mother and the neighbour on the grounds of diminished responsibility. He was sentenced to a Hospital Order with a S.41 Mental Health Act Restriction Order. He cannot be released without the authority of the Secretary of State.

3: Conclusions and recommendations

- 3.1 From the evidence available to the Review from the individual management reports, there is nothing to suggest that this event could have been predicted or prevented. There is no suggestion of a motive and no prior warning other than the phone call to the Police immediately after the action was taken. The family holds the same view.
- 3.2 As noted above neither Adult 1 nor Adult 2 were known to many services and there was no indication of any domestic violence or abuse in their relationship. In particular there are no records within the Housing Services records of complaints or concerns raised by the neighbour or any other resident. The review panel considered the implications of the alleged domestic abuse incident (for which there was no conviction) relating to a former partner in 1999 but concluded that this was not relevant in this case.
- 3.5 Mental health services failed to notify the G.P. of Adult 2's discharge from the service in January 2012 together with the fact that he had cancelled three appointments and had not, therefore, been seen since the original referral. This was contrary to the discharge policy in place and the review panel was assured that this was not normal practice.
- 3.6 Whilst it is extremely unlikely that the G.P.'s awareness of these facts would have made any difference to the outcome; the lack of knowledge of this combined with the lack of review of the patient's mental health does mean that there was no formal monitoring of Adult 2's mental health for some considerable time prior to the event. When last seen by the G.P. (in July 2012) a further prescription of anti-depressants was issued but there is nothing to suggest any wider discussion of his mental health.

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- 3.7 Issues relating to prescriptions have arisen previously in both an adult and a children's serious case review in respect of individual G.P. Practices. There is a need to ensure that such findings are shared more widely across all G.P. Practices.
- 3.8 The two organisations concerned have identified these issues in their individual reports and have made specific recommendations in relation to them.
- 3.9 It is acknowledged that Adult 2 appears to have declined many services such as those relating to alcohol use; anger management and depression awareness; and that he also cancelled a number of other appointments. It is also accepted, however, that in most circumstances such services can only be offered, not imposed.
- 3.10 In order to maximise the learning from this review, whilst acknowledging that it is unlikely to have affected the subsequent events in this case, the panel has agreed to expand the recommendation regarding repeat prescribing into a review recommendation for all Practices within the Area Team's remit.

The Review, therefore, makes the following recommendation, which has been implemented:

That, in order to ensure safe practice and patient care, the Safer Sandwell Partnership ask NHS England, Birmingham, Solihull and Black Country Area Team to remind all GPs practices of the potential risks of repeat prescribing protocols, particularly for patients with mental health issues.. To support and inform best practice the NHS England, Birmingham, Solihull and Black Country Area Team will also circulate the Medical Protection Society guidance "Repeat prescribing for GPs" (March 2013) to all GP practices.

- 3.11 It is further noted that, of the 19 DHRs undertaken within the West Midlands as at June 2013, 13 included issues apparently relating to mental health.
- 3.12 The Review panel agrees that the threshold for holding the review as defined in the legislation was met. However, since the undertaking of a review is not an end in itself but a means of learning lessons for the future, the panel questions whether the current approach detailed in the guidance² was the most effective in this case.
- 3.13 The Panel is aware that the Home Office has recently revised the statutory guidance³. The Panel feels, however, that the guidance could be further improved by adopting a similar approach to that now applicable to children's serious case reviews, namely the option of utilising different models of review⁴.

² Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews HO

³ Multi-Agency Statutory Guidance for the conduct of Domestic Homicide Reviews. Revised - applicable to all notifications made from and including 1 August 2013 HO

⁴ Working Together to Safeguard Children 2013: Reference: DFE-00030-2013

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The Review, therefore, makes the following recommendation, which the Safer Sandwell Partnership has acted upon:

That; in order to optimise the use of agencies' resources (notably time and money) most effectively and efficiently, whilst still achieving the purpose of the domestic homicide review; the Safer Sandwell Partnership asks the Home Office to consider the option of different approaches to the undertaking DHRs in different circumstances (cf: the new guidance in relation to children's reviews).

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