



SAFER SANDWELL PARTNERSHIP

Overview Report

Domestic Homicide Review of the circumstances concerning

Independent Chair and Author

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1: Introduction

1.1 Domestic Homicide Reviews

- 1.1.1 Domestic Homicide Reviews (DHR) are one way to improve responses to domestic abuse. They aim to prevent what happened in any given case being repeated in others.
- 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.
- 1.1.3 Primarily, the purpose of a 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
- 1.1.4 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.

1.2 Local Context

- 1.2.1 Sandwell is a metropolitan borough which was formed in 1974, and is one of seven authorities that make up the West Midlands conurbation. It has a population of approximately 309,000 and is an ethnically diverse borough with a white British population of 65.8% and an Asian population of 19.2% (June 2011 estimate). In absolute terms, health in Sandwell has been improving over time, though at a slower rate than the country as a whole. Life expectancy in Sandwell is 75.5 years for men and 80.8 for women, compared to the national figures of 78.6 and 82.6 years respectively (3 year rolling average 2008/10). In August 2013, 6.3% of the local working age population (16-64) claimed Job Seekers' Allowance compared to 4.1% within the West Midlands and 3.3% within Great Britain as a whole.
- 1.2.2 Sandwell has a Domestic Abuse Strategic Partnership (DASP) which aims to lead a co-ordinated effort to reduce, and where possible, prevent incidences of domestic abuse. Key statutory and voluntary organisations are active members of the DASP, which is chaired by a chief officer from Sandwell Council. The DASP is accountable to the Safer Sandwell Partnership, the statutory community safety partnership for the borough which has partner representation at a senior / chief officer level.
- 1.2.3 At the time of finalising this report, Sandwell had recently agreed a new Domestic Abuse Strategy 2013-16. A Multi-Agency Safeguarding Hub

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

(MASH) was launched in November 2013 which incorporates domestic abuse screening using the DASH risk assessment and Barnardo's Screening Tool. The partner agencies involved in MASH are Children's Social Care, Adult Social Care, Family Support, Police, Probation, Housing, Health including Mental Health, Sandwell Women's Aid, Community Safety and Targeted Youth Support.

1.2.4 A new Early Help Strategy has also been developed which aims to provide earlier help to children and families including those experiencing domestic abuse.

1.3 Circumstances leading to this review

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
Adult 3	Son of Adult 1 and older brother of Adult 2
Adult 4	Elder Daughter of Adult 1 and sister of Adult 2
Adult 5	Younger daughter of Adult 1 and sister of Adult 2. This is the person who provided family information to the review.

1.3.1 Adult 1 died in October 2012. Police officers attended the address following an emergency call 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. He was arrested on suspicion of murder.

1.3.2 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.

1.3.3 The information from partner agencies was shared with the Chair of the Safer Sandwell Partnership who decided that the criteria for holding a Domestic Homicide Review under Section 9 (3) of the Domestic Violence, Crime and Victims Act (2004) was met and directed that such a review be carried out into the circumstances surrounding this case.

- 1.3.4 It was agreed by that Partnership that the neighbour would not be a subject of this review. He was not a family member and there was no evidence of any link between him and Adult 1 or Adult 2 in any capacity.
- 1.3.5 Further conversation with Adult 5 and a search of the neighbour's record by the Housing provider have confirmed this. Adult 5 commented that they were 'just neighbours' with no other relationship, and it was her understanding that he had come out from his flat opposite Adult 1 that night on hearing a disturbance. (See also 2.4 below)
- 1.3.6 Further information from the police referring to statements taken from peers after the murder indicates that Adult 2 and the neighbour were only passing acquaintances. In a statement provided to the police, Adult 2 said that the neighbour 'was in the wrong place at the wrong time, I think he lived opposite her'. This would also suggest that Adult 2 and the neighbour were not closely known to each other and the attack on the neighbour was without motive or provocation.

1.4 Process undertaken for this review

- 1.4.1 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). This panel has also assisted the Chair in formulating recommendations based on their conclusions and those of the individual report writers.
- 1.4.2 The panel was comprised as follows:

Anne Cole: Independent Chair

Detective Chief Inspector: West Midlands Police
Community Safety and Domestic Violence Manager: Sandwell Council
Head of Probation: Sandwell Local Delivery Unit
Designated Nurse, Safeguarding Children: Sandwell and West Birmingham
Clinical Commissioning Group
Protection Lead Officer, Sandwell Safeguarding Adults Board
Social Care Director: Black Country Partnership NHS Foundation Trust
Quality and Safety Manager: Nursing & Quality Team (Birmingham, Solihull
and the Black Country) Area Team NHS England

The panel was assisted by administrative support from Sandwell Council
Community Safety Team.

- 1.4.3 At their first meeting, the panel also considered whether panel members from the voluntary or community sector or with a specific Domestic Violence specialism were required but concluded that, on the basis of the information available at this time, no additional members would be needed to provide specific expert advice at this stage. Several Panel members had experience and expertise in working with both victims and offenders or had access to

specialists within their own organisation. The panel retained the option, however, of co-opting other members at a later date if the information obtained in the course of the review process indicated such a need. This did not prove to be the case.

- 1.4.4 The chair of the review panel, and author of this report, is independent of all of the local agencies and professionals involved in the case, and of the Safer Sandwell Partnership. She is a qualified and registered social worker who has spent nearly 30 years working within Local Authority Social Services. Having begun her career as a generic social worker, she worked for many years as a middle and senior manager. Most of her work has been within Children & Families Services specialising latterly in safeguarding. She was also responsible for the establishment and management of a Safeguarding Adults Team and an active member of a number of partnership arrangements including the Multi-Agency Public Protection Arrangements Strategic Management Board; the Multi-Agency Risk Assessment Conference steering group; and the domestic abuse steering group as well as the Local Safeguarding Children Board (LSCB) and the Safeguarding Vulnerable Adults Board. Since October 2009 she has worked as an independent manager/consultant: providing advice and support to LSCBs; chairing serious case review panels; undertaking management reviews and the investigation of complaints for adult services and also undertaking project work; practice audits; and peer evaluations within operational children's services.
- 1.4.5 IMRs were requested from: West Midlands Police; Sandwell PCT (GPs), (Now Sandwell and West Birmingham Clinical Commissioning Group); Black Country Partnership NHS Foundation Trust; Sandwell Homes (now Sandwell Council Neighbourhood Services); and Sandwell and West Birmingham Hospitals Trust. 'Helpful reports' were requested from Sandwell Council Adult Services and subsequently, during the course of the review, from Walsall Manor Hospital.
- 1.4.6 In addition information was requested from a number of other organisations: Sandwell Council Children's Services; Staffordshire and West Midlands Probation Trust; West Midlands Ambulance Service; Sandwell Women's Aid; and the Youth Offending Service; all of whom submitted 'nil returns' stating that neither Adult 1 nor Adult 2 were known to them.
- 1.4.7 All authors were asked to consider a standard set of terms of reference as follows:
- Were practitioners sensitive to the needs of the victim and the perpetrator, knowledgeable about potential indicators of domestic violence and aware of what to do if they had concerns about a victim or perpetrator?
 - Was it reasonable to expect them, given their level of training and knowledge, to fulfil these expectations?

- Did the agency have policies and procedures for risk assessment and risk management for domestic violence victims or perpetrators (DASH) and were those assessments correctly used in the case of this victim/perpetrator?
- Did the agency have policies and procedures in place for dealing with concerns about domestic violence?
- Were these assessments tools, procedures and policies professionally accepted as being effective? Was the victim subject to a MARAC?
- Did the agency comply with domestic violence protocols agreed with other agencies, including any information sharing protocols?
- What were the key points or opportunities for assessment and decision making in this case?
- Do assessments and decisions appear to have been reached in an informed and professional way?
- Did actions or risk management plans fit with the assessment and the decisions made?
- Were appropriate services offered or provided, or relevant enquiries made in the light of the assessments, given what was known or what should have been known at the time?
- When, and in what way, were the victim's wishes and feelings ascertained and considered?
- Is it reasonable to assume that the wishes of the victim should have been known?
- Was the victim informed of options/choices to make informed decisions?
- Were they signposted to other agencies?
- Was anything known about the perpetrator? For example, were they being managed under MAPPA?
- Had the victim disclosed to anyone and if so, was the response appropriate?
- Was this information recorded and shared, where appropriate?
- Were procedures sensitive to the ethnic, cultural, linguistic and religious identities of the victim, the perpetrator and their families?
- Was consideration for vulnerability and disability necessary?

- Were Senior Managers or agencies and professionals involved at the appropriate points?
- Are there other questions that may be appropriate and could add to the content of the case? For example, was the domestic homicide the only one that had been committed in this area for a number of years?
- Are there ways of working effectively that could be passed on to other organisations or individuals?
- Are there lessons to be learnt from this case relating to the way in which this agency works to safeguard victims and promote their welfare, or the way it identifies, assesses and manages the risks posed by perpetrators? Where could practice be improved? Are there implications for ways of working, training, management and supervision, working in partnership with other agencies and resources?
- How accessible were the services for the victim and the perpetrator?
- To what degree could the homicide have been accurately predicted and prevented?

1.4.8 These terms of reference were agreed by the review panel at their first meeting. It was further agreed that, on the basis of information then available, there were no additional terms of reference specific to this review. The panel retained the option, however, of amending the terms of reference if additional information obtained in the course of the review process indicated such a need. This did not prove to be the case.

1.4.9 At this meeting the panel also agreed the scope of the review in terms of time. It was decided that this should be from 1999 to the date of Adult 1's death (October 2012) since 1999 was the first reference known to the panel of any mental health issues relating to Adult 2. IMR authors were advised, however, that any relevant information which was available which fell outside this time frame should be included in their report.

1.4.10 The management reports confirmed what had previously been suggested in the agencies' initial responses: namely that neither Adult 1 nor Adult 2 were known to many services and further confirmed that no agency was aware of any domestic abuse between the two. As a result, this review has been undertaken entirely by reports, with additional clarification by authors as necessary to ensure the quality of the reports and the information available to the review, and no report writer has been required to attend the review panel.

- 1.4.11 Each author has confirmed that they had no direct involvement with the individuals concerned and each report has been counter-signed by a senior member of the relevant organisation.
- 1.4.12 In July 2013, after several psychiatric assessments, Adult 2 pleaded guilty to the manslaughter of his mother and the neighbour on the grounds of diminished responsibility and was sentenced to a Hospital Order with a S.41 Mental Health Act Restriction Order. He remains to date, at a secure unit for men with severe mental health problems.
- 1.4.13 Earlier in the review process, family members were advised that the review was being undertaken, but that they could not be directly involved until after the criminal proceedings had been concluded. This also meant that the review could not be completed within the required timescale (June 2013). The Home Office were advised of this and of the reason for the delay which was accepted.
- 1.4.14 Following the conclusion of the criminal proceedings, family members were invited to participate in the review. Adult 5 was keen to do so; she felt that her brother, Adult 3, would not wish to be involved and that her sister, Adult 4, might wish to be. It was agreed that she would speak with them and invite them to be involved if they wished. They decided not to participate, although Adult 4 was willing to be contacted if there were any specific queries. Initially a meeting was agreed but this had to be postponed due to Adult 5's daughter's illness. Subsequently, Adult 5 asked if the interview could take place by telephone. This was agreed and a conversation took place between the Review Chair and Adult 5.
- 1.4.15 Once the overview report had been approved by the Safer Sandwell Partnership, Adult 5 was contacted again to invite her, or other family members, to read the outcome of the review. They declined.
- 1.4.16 In following up the queries made by the Home Office however, Adult 5 was contacted again in August 2014 and, on this occasion, was willing to talk to the Chair of the Review. Her comments are included in the relevant sections of this report.
- 1.4.17 In view of the fragile mental state of Adult 2, as identified during the criminal proceedings, it was not felt appropriate to invite him to participate in this review.

2: The Facts

- 2.1 As outlined above, Adult 1 was killed in October 2012 and was found by Police Officers in her bed. She lived alone in a block of flats in which both her sons (Adult 2 and Adult 3) were also tenants. Adult 2 was named as her next of kin in her tenancy agreement. She had lived at this address since November 1997 but was born in the area and had lived there all her life. Adult 1 was in her late 60's when she died.

- 2.2 Adult 2 became a tenant in the same block in June 2009 citing as a reason for this choice of address the fact that that he was his mother's carer.
- 2.3 At the inquest, the cause of death was established as 'penetrating stab wounds'. Following the conclusion of the criminal proceedings, the Coroner confirmed that the inquest would be concluded without being re-opened.
- 2.4 Adult 2 was charged with the murder of his mother and the neighbour. Information from the police regarding the examination of the murder scene suggests that Adult 2 attacked his mother first and then dialled the police on her landline to state that he had committed murder. The phone was then found in the communal corridor having been destroyed against the neighbour's front door. The handset was found to have Adult 1's blood on it which forensically supports the theory that she was dead at the time of the call to the police. It is believed that the neighbour was roused by this action and fatally stabbed in the hallway area when he went out to investigate. Drag marks in this area suggest he was then thrown by Adult 2 over the balcony to the area where he was discovered by officers.
- 2.5 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 eventually 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, to be detained in a secure mental health facility indefinitely and cannot be released without the authority of the Secretary of State.
- 2.7 Family Context
- 2.7.1 As already noted, little was known by any agency about Adult 1 or Adult 2 or their family circumstances and, even following a conversation with Adult 5, little additional information has been gained.
- 2.7.2 Adult 1 was born in 1943 and grew up in the local area where she subsequently married Adult 2's father and had four children: Two sons, Adults 2 and 3 and two daughters, Adults 4 and 5. All are White British. Her husband died at the age of 38 following a heart attack. Adult 2 reported to the mental health team that he had witnessed this. Adult 1 later re-married but had lived alone for several years following her second husband's death.
- 2.7.3 It is recorded within the West Midlands Police report that Adult 1 had a good relationship with all her children and it is known that both her sons lived in the same block of flats. Adult 2 was named as her next of kin despite being the younger of the two sons. In 2000 however, Adult 2 had stated to the mental health team that he 'was not close to his mother and had no feelings for her'. He also stated that he was brought up 'by his Nan'.

- 2.7.4 During the conversation in August 2013, Adult 5 confirmed that Adult 2 had been brought up by his grandmother, although she was not aware of the reason for this.
- 2.7.5 In a further conversation with Adult 5, (in August 2014) she explained that she had since spoken with her brother and sister about this and all three of them were of the opinion that because Adult 2 was 'a bit of a handful' their 'Nan' had decided to step in. This took place when Adult 2 was approximately 10 years old. At this time Adult 1's husband had died and she was caring for four children. Adult 5 was keen to clarify that by 'a bit of a handful' she did not mean 'anything serious'.
- 2.7.6 In the same interview with mental health services (referred to in 2.7.3) in 2000, it is recorded that Adult 2 stated that he had met his partner when he was 18 years old; that they lived together for 12 years (until 1999) and that he had three children. At the time of the murders, they were all adults.
- 2.7.7 There is a discrepancy within the different reports as to whether Adult 2 had two or three children. Some reports suggest that the third child of his ex-partner was born after they separated and is the result of a subsequent relationship. In conversation with Adult 5, she confirmed that Adult 2 did have three children, twin boys and a daughter, but that his ex-partner had also had a child subsequently. This is presumably the source of the confusion.
- 2.7.8 According to Adult 5; Adult 2 has had no further partners.
- 2.7.9 In conversation with Adult 5, she confirmed that there was no history, as far as she was aware, of any violence between Adult 2 and his mother. She also confirmed that there had been violence between him and his former partner. She recalled that on one occasion she (Adult 5) had had to intervene. Following the couple's separation (1999) Adult 5 recalled one or two occasions where there had been further arguments regarding Adult 2's desire to see his children. It is not clear whether any physical violence was involved and, as far as Adult 5 is aware, the partner at no time sought any help.

2.8 Agency involvement

- 2.8.1 Only four reports have any record of Adult 1: Sandwell and West Birmingham Clinical Commissioning Group (her G.P); Walsall Manor Hospital; Sandwell Council Neighbourhood Services; and Sandwell Council Adult Services.
- 2.8.2 All refer to her medical needs, mainly relating to her diabetes, which had resulted in eye disease; poor mobility; and renal problems.
- 2.8.3 **The G.P.** records that she was 'appropriately managed by the relevant primary care teams and that she attended for most of her nurse checks and blood tests but on occasions missed appointments'. Her last recorded contact with the G.P. practice was September 2012.

- 2.8.4 The report from **Walsall Manor Hospital**, however, records the G.P. as stating that she was a 'regular non-attender' when referring her in 2010 for concerns regarding renal functioning. Her last appointment at the hospital was in October 2011 when she was discharged back to the G.P for on-going management.
- 2.8.5 There is no reference to any domestic violence concerns in either report but it is noted that the G.P. records were 'very concise with no social issues mentioned' and the Hospital reports that there is no evidence that any questions regarding 'lifestyle' issues were discussed.
- 2.8.6 **Sandwell Council Neighbourhood Services** (formerly Sandwell Homes) refer to some early issues regarding rent arrears which appear to have been resolved and latterly (from 2010) visits relating to repairs which also note mobility problems and a referral to Adult Services. Despite several direct contacts with Adult 1, there is no indication in the records of any suggestion of domestic abuse or concerns. The report writer also comments that there are no records of complaints from neighbours regarding noise or disturbance which is often an indicator of such issues. The last contact by Neighbourhood Services was September 2012. In responding to the Home Office queries in July 2014, the original report author has checked the records of Adult 1 and Adult 2 again and those relating to the neighbour. This strengthens the view that there were no concerns expressed prior to this incident regarding domestic abuse. Furthermore, there were no records of complaints from the neighbour who was killed, or reference to a relationship of any kind between Adult 1 or 2 and the neighbour.
- 2.8.7 **Sandwell Council Adult Services** do not have a record of the referral from Housing Services but had received a referral earlier in 2010 from the eye clinic, requesting an assessment. There was considerable delay in offering this assessment (over three months) and, at that point, Adult 1 declined. In reality, therefore, the Service had no direct contact with Adult 1 which would have enabled any discussion about any other issues.
- 2.8.8 Five of the reports have a record of involvement with **Adult 2**: Sandwell Council Neighbourhood Services; Sandwell and West Birmingham Hospitals Trust; Sandwell and West Birmingham Clinical Commissioning Group (the G.P. Practice); The Black Country Partnership NHS Foundation Trust (Mental Health Services); and West Midlands Police.
- 2.8.9 **Neighbourhood Services** had contact at the start of his tenancy in 2009 and at that point recorded a self-reported mental health issue. The report states however that 'there were no other concerns identified with regard to his management of a tenancy or his mental health'. Adult 2 requested this particular address as he stated that he was his mother's carer. The last recorded contact was in July 2010. This was a routine visit which recorded 'no change in information or tenant profile. Home conditions acceptable'. There is no suggestion of any concerns relating to domestic abuse nor, as noted above, any complaints from other residents including the

neighbour who was killed at the same time as Adult 1, which could have been an indicator of such issues.

2.8.10 In 2004 Adult 2 had contact with **Sandwell and West Birmingham Hospitals Trust** in relation to two accidents: one a scald as a result of dropping a hot drink and the other following a fall onto a nail.

2.8.11 Although not recorded in the hospital's report, it is suggested elsewhere (within the IMR for mental health services) that the former occurred when Adult 2 was intoxicated. The latter required surgery and the only concern noted was that Adult 2 was violent post-operatively leading to the consideration of a psychiatric review but as he calmed down this was not felt to be necessary.

2.8.12 There was no suggestion of any domestic abuse in the records.

2.8.13 The only other contact with the Trust was for an ECG in October 2011 following a G.P. appointment where Adult 2 complained of headaches and nausea. The follow up appointment at the G.P. practice records that no further action was necessary.

2.8.14 Adult 2 has been known to the **G.P. Practice** since birth (1969). This was the same practice as Adult 1. The IMR reports that there is a reference in the GP record in relation to depression in 1999 and a referral to a psychiatrist was made at that time. After this period Adult 2 did not access medical services until he was seen again for depression in 2002. He remained on medication for his mental health problems and attended the GP surgery for asthma management. He was seen again in 2008 and was referred to the mental health team. It is documented that he did not attend this appointment. The information in the GP records for Adult 2 indicates that he had a history of depression, and paranoia together with some reference to cannabis and alcohol abuse.

2.8.15 Further information records that Adult 2 was prescribed anti-depressant medication for many years although there were periods when he chose not to take this and there were also a number of missed appointments.

2.8.16 The G.P. notes indicate that for some time Adult 2 was engaging with mental health services. He was seen in 2001 expressing symptoms of paranoia and there is reference to being seen by a consultant in 2002 and by a member of the team in 2004. (See also 2.8.24 below)

2.8.17 In October 2008, Adult 2 requested a referral to a psychiatrist although the G.P. record does not indicate why. There are notes relating to further G.P. appointments in May 2009 and June 2009 but no reference to depression or any evidence of a review of mental health issues. A formal mental health

assessment was undertaken in March 2010 which indicated 'moderate depression'.

2.8.18 From April 2010 until at least February 2012, Adult 2 was issued with 'sick notes' by the Practice.

2.8.19 Although reference is made to concerns relating to his alcohol intake; Adult 2 refused to engage with alcohol services.

2.8.20 There is no reference in the notes to indicate any concerns regarding domestic abuse.

2.8.21 Adult 2 was last seen by the G.P. in July 2012 when further anti-depressants were prescribed. No reference is made to any deterioration in his mental state.

2.8.22 As noted above, the **Black Country Partnership NHS Foundation Trust (Mental Health Services)** first received a referral in respect of Adult 2 in December 1999 in relation to his depression. He was offered an appointment in August 2000 (8 months later) which he cancelled. After cancelling a further appointment, he was finally seen in December 2000. Following this appointment; during which Adult 2 stated that he was drinking 8 cans of cider a day in addition to lager and was also smoking cannabis on a weekly basis; he was referred to the Anchor Project (Alcohol Services) and offered a further out-patients appointment. Adult 2 failed to attend the appointment with alcohol services but did attend two further appointments with the mental health team. In January 2002, Adult 2 reported drinking less but also suffering anxiety and panic attacks. He was prescribed anti-depressants and advised to attend depression awareness and anxiety management courses. There is no information as to whether or not he followed this advice.

2.8.23 Adult 2 continued to engage with mental health services during 2002 and 2003. In July 2003 he stated that he was 'eating and sleeping fine and had reduced his drinking'. However by October 2003 his drinking had increased and he agreed to contact the Anchor Project. He missed his next appointment in March 2004 and in April 2004 he declined a referral to the Project.

2.8.24 In September 2004 Adult 2 was seen by a member of the mental health team in the out-patients department following the accident referred to at 2.8.10 above. He was advised to reduce his drinking and to take his medication regularly. The doctor who saw him stated that he did not feel that the service could offer him any further assistance until he was able to comply with these measures and therefore discharged him back to the care of his G.P.

2.8.25 In September 2011 Adult 2 was referred to the mental health service by his G.P. for counselling. He responded to the invitation to 'opt in' to the service but cancelled three offers of appointment and was discharged in January 2012 without being seen and without reference to the referring G.P. This was contrary to the Discharge Policy then in place.

- 2.8.26 There had, therefore, been no direct contact between Adult 2 and mental health services since 2004, until he was seen immediately after his arrest on suspicion of murder when a mental health assessment was undertaken.
- 2.8.27 This surprised Adult 5 when it became clear during the criminal proceedings. She stated that she believed that Adult 2 was ‘under a psychiatrist’ and that as his mental health issues had existed for ‘at least 10 years’ she was surprised that this had not been picked up. She also stated, however, that “he had not seemed any different recently” prior to the murder of Adult 1; she had seen him only ‘a couple of days before’ and she had not identified any deterioration in Adult 2’s mental health. (See also 4.2 and 4.5 below)
- 2.8.28 At the point of his arrest, Adult 2 was described in the initial assessment as being ‘unpredictable and a high risk of violence based on his psychotic symptoms’. It would appear that this deterioration must have been rapid.
- 2.8.29 Adult 2 was known to **West Midlands Police**, although prior to his arrest in 2012, the last involvement was in 2006 and this was not related to domestic abuse.
- 2.8.30 Adult 2 had six previous convictions, dating back to 1985. Prior to the incident in October 2012, his most recent previous conviction was in 1999 for criminal damage.
- 2.8.31 The other convictions all date back more than 20 years.
- 2.8.32 The Police report author notes ‘He came to police attention in the period between 1999 and 2006 on a relatively limited number of occasions. His contact with police was generally due to him being arrested for minor offences, committed whilst he was under the influence of alcohol’.
- 2.8.33 The conviction in 1999 related to an alleged domestic abuse incident reported by his former partner from whom he had recently separated. He was initially charged with criminal damage and assault but was not convicted of the latter. Full details of the incident (including any reason why the charge of assault was not upheld) have been destroyed in line with Police retention and destruction policies but it is clear from the Police IMR that the matter was taken seriously in terms of possible domestic abuse. The custody officer observed signs of drunkenness and sought a medical assessment. Adult 2 was deemed to be fit to be interviewed and was retained in custody overnight. He was charged with three offences of criminal damage and an assault and was then remanded in custody for a further 24 hours until he appeared in court.
- 2.8.34 There are no other references within the Police records of any domestic abuse incidents and none relating to the relationship with his mother. This was confirmed by Adult 5.

2.8.35 In August 2004, the Police were involved following an assault on the manager of a public house and another customer. The manager reported that Adult 2 'often did things that were 'odd'' such as staring at customers for prolonged periods. The matter was not dealt with until some time after the incident and in the meantime the complaint was withdrawn.

2.8.36 In January 2005 Adult 2 was arrested to prevent a breach of the peace following reports of him refusing to leave a shopping centre. The police officer recorded that Adult 2 was intoxicated at the time. Once he arrived at the custody block, however, he was released with no further action being taken.

2.8.37 In August 2005 Adult 2 was arrested on suspicion of affray following a report of a male 'acting suspiciously with a golf club'. The custody officer recorded that Adult 2 was taking medication for depression. Adult 2 also self-reported the consumption of five cans of alcohol and it was noted that he did appear drunk. He also told the custody officer that he had attempted self-harm in 1999 but had no current issues. As a result of these disclosures, a medical assessment was requested. The conclusion of this was that Adult 2 was fit to be detained and interviewed. He denied any offence, stating that he was merely practising golf on the playing field and, as there was insufficient evidence that any offence had taken place, he was released with no further action.

2.8.38 In October 2006, Adult 2 was arrested for being drunk and disorderly in a local town centre. When approached by Police officers he became verbally abusive and on arrest he became violent and had to be restrained. Whilst in custody he was again subject to a medical assessment which again concluded that he was fit to be detained. He was subsequently issued with a fixed penalty ticket for being drunk and disorderly in a public place.

2.8.39 This was the last contact with the Police until the incident leading to his arrest on suspicion of murder.

2.8.40 Adult 5 was unable to identify any other agency which may have been involved with either Adult 1 or Adult 2 or could provide any additional information to the review

3: Analysis

3.1 Terms of reference

3.1.1 Although the panel agreed to use the standard terms of reference as outlined in 1.4.8 above; it was acknowledged from the outset that some areas may not be relevant to all IMRs. For example, some services only had knowledge of one of the subjects, Adult 1 or Adult 2, and, as anticipated, none had identified any prior indication of domestic abuse between the two.

3.1.2 Rather than deal with each in turn, therefore, this report will collate overall responses to the terms of reference into the following subject areas and will highlight any particular issues.

Professional practice

3.1.3 Where authors responded to the terms of reference in more general terms (i.e. not specifically in relation to this case) all confirmed that their staff are aware of indicators of abuse and that their training should make them sensitive to such issues and how to deal with them. Some commented however that the involvement of their service with the individuals in this particular case was some years ago when domestic abuse was not understood as well as it is now.

3.1.4 All were able to identify key points or opportunities for assessment and decision making and, where appropriate, commented on these being reached in an informed and professional way. Again, these comments related more generally to the issues presented or the service being provided rather than in relation to domestic abuse. For example, the police assessments related to custody decisions and those within the mental health services to Adult 2's current state of health. The G.P. report refers to many assessments in relation to Adult 1 but does acknowledge missed opportunities to re-assess Adult 2's mental health in relation to repeat prescriptions. This observation has led to both a single agency and a Review recommendation.

3.1.5 In response to the question relating to the provision of services, most felt that, in relation to their service, this was appropriately offered or provided. Mental Health Services commented that those offered in respect of alcohol issues were not taken up by Adult 2. The Police report makes reference to the fact that there were no referrals from them to other agencies and comments that although there were indicators that Adult 2 may have been suffering from mental health issues his behaviour could equally have been attributable to the effects of alcohol.

Policies, procedures and protocols

3.1.6 All agencies commented that they had policies and procedures in place for risk management in relation to domestic abuse, but several commented that they had had no need to use these as no risk had been identified. Two (mental health services and the Hospital Trust) also commented that the use of the DASH² risk assessment would not have been in their policies at the time of their involvement with Adult 2. Reference was also made to information sharing protocols now in place and the membership of several agencies on MAPPA and MARAC³ panels.

² Domestic Abuse Stalking and Harassment

³ Multi-Agency Public Protection Arrangements / Multi Agency Risk Assessment Conference

- 3.1.7 West Midlands Police also refer to the development of a 'Safer Detention Policy', introduced in November 2011 (and, therefore, some time after Adult 2's last arrest). This policy places an emphasis upon a dynamic risk assessment of persons in custody who appear to have a mental illness. It places upon custody staff a responsibility to risk assess the person upon their release, identifying any risk to themselves, their carers or the wider public. It requires a more proactive consideration and documentation of risk. However, as noted above, whether Adult 2 was displaying mental illness problems or simply behaviours related to the effects of alcohol was never determined and, therefore, even if the policy had been in place at the time, it may not have been implemented in this case.
- 3.1.8 The only instance identified of a failure to follow policy relates to the discharge of Adult 2 by mental health services as outlined in 2.6.25 above. This has been addressed within the individual recommendation for the agency.

Agency responses to the victim

- 3.1.9 The terms of reference relating to responses to the victim all pre-suppose concerns about, or disclosure of, domestic abuse. As this was not the case; none of these terms of reference were relevant.

Knowledge of the perpetrator

- 3.1.10 Again, the terms of reference relate to domestic abuse which was not an issue in any agency's dealings with Adult 2 in respect of Adult 1. The only point at which there was any comment relating to relationship difficulties was in 2000 when Adult 2 told the mental health team that he had 'no feelings' for his mother. (See 2.7.3) This is contradicted however by his request to move to the same block of flats as Adult 1 as he was her carer. (See 2.8.9).
- 3.1.11 The perpetrator does have a long history of mental health issues, as detailed in the GP and mental health service chronologies. Indeed the scope of the review was determined by the first reference known to the panel of mental health issues in 1999.
- 3.1.12 He also appears to have a history of failing to attend appointments and of declining services offered, particularly in relation to alcohol misuse. There is, however, no record of any suggestion that this made him a danger to himself or to others.
- 3.1.13 A number of agencies record the use of a range of different substances. These are all based on self-reporting. Some refer to alcohol; some to cannabis; some to butane. The Police and Sandwell Council Neighbourhood Services reports also record his self-reporting of mental health issues, although the Police also comment that, in their dealings with Adult 2 there appeared to be some doubt as to whether his presentation was due to mental health issues or the effects of alcohol.

3.2 Lessons learnt

- 3.2.1 The report in relation to the G.P. Practice identified issues pertaining to repeat prescribing. Panel members are aware that similar issues have arisen previously in both an adult and a children's serious case review in respect of individual G.P. Practices. The Children's SCR relates to Child F which was conducted in 2008 and highlighted issues with respect to the monitoring of medication compliance in respect of both Mother and Child in this case. A recommendation that "Each GP practice complete a comprehensive medication review in accordance with GMC good medical practice guidelines" was identified and implementation of this action was built in to the Quality Outcome Framework Inspections that were carried out annually at this time by the Clinical Governance Department of Sandwell Primary Care Trust. In further discussion it was decided that the issues within the children's SCR were significantly different from those identified within this review.
- 3.2.2 The Chair of the Adult Safeguarding Board was contacted to ensure that any lessons learnt from the Adult SCR were shared as widely as possible. The Chair confirmed that the recommendation from the adult case review was that 'The Medical Director to remind all GP Practices that all patients suffering from a mental health condition should have an annual medication review and a mental health review ,if appropriate, according to the GP contract and that some detail of these reviews are documented'. The Chair noted, however, that this was when PCT's were still in existence and a Medical Director in place.
- 3.2.3 In view of the changes within Health arrangements, the recommendation from this review is slightly different. It still picks up the key elements however of the need to oversee patients on repeat prescriptions and that lessons learnt should be shared as widely as possible
- 3.2.4 Other organisations noted ways in which services could be improved in a more general sense, or where practice had developed since the agency's involvement with either Adult 1 or Adult 2.
- 3.2.5 The Hospitals Trust and Mental Health Services highlight their revised domestic abuse policies whilst the Police IMR refers to the development of the safer detention policy.
- 3.2.6 The Hospitals Trust also noted a need to raise awareness regarding domestic abuse across the organisation; and Adult Services acknowledged the considerable delay in offering Adult 1 an assessment following referral in 2010 and the need to review current performance.
- 3.2.7 The Review Panel are also aware of the development nationally of the transfer of police healthcare commissioning to the NHS with the aim of improving access to medical records and, thereby, ensuring appropriate medical and psychiatric treatment for those in custody.

4: Conclusions and recommendations

- 4.1 From the evidence available to the Review by way of the individual management reports, there is no suggestion of a motive.
- 4.2 Adult 5 confirmed that the family could offer no explanation as to why this had happened. She said that she had seen Adult 2 'a couple of days before' and he had seemed 'fine'. In response to the comment that this seemed to have come 'out of the blue', she stated 'definitely' and confirmed that in her opinion her mother's death could not have been predicted or prevented.
- 4.3 Adult 5 repeated in the later conversation that she did not believe that her mother's death could have been 'predicted in any way'. As a result of a letter received from Adult 2, Adult 5 believes that the event was precipitated by Adult 2's use of drugs; a fact which has made her angry as she believes that it was preventable by Adult 2 himself.
- 4.4 There are no proposed recommendations from family members.
- 4.5 The assessment immediately following his arrest, which recorded 'psychotic symptoms', leads to the assumption that Adult 2's mental health had deteriorated rapidly prior to this event. No agency had identified this however; neither Adult 2 nor any family member had raised concerns; nor were there any reports from the general public, such as other residents in the block of flats, to suggest any fear of violence. Adult 5 did say that she was under the impression that Adult 2 was receiving mental health treatment and that it was only during the criminal proceedings that she became aware that this was not the case. She confirmed however that she had not perceived any deterioration in Adult 2's behaviour or mental state.
- 4.6 It is acknowledged that there was an alleged domestic violence incident in 1999. This related to the relationship between Adult 2 and his ex-partner. He was charged with assault and criminal damage. The court did not uphold the charge of assault and he was not convicted of this. The Panel considered these factors and concluded that this particular incident was not relevant in respect of the subsequent death of Adult 1.
- 4.7 As noted above, none of the participating agencies, nor the family had any concern regarding the relationship between Adult 1 and Adult 2 and there was no suggestion from the general public of any problems. There was no evidence of domestic abuse in their relationship. In view of this the unanimous view of the review panel was that this event could not have been predicted or prevented.
- 4.8 Reviews often refer to a 'lack of communication between agencies' implying a failure of some kind. In this case, there appear to be two such instances. The first refers to the referral of Adult 1 to Adult Services by Housing Services which does not appear to have been received. In turn, no follow up was undertaken to see why no response had been made. However, this would

have had no bearing on subsequent events and, in any case, Adult 1 had declined an assessment by Adult Services only three months previously.

- 4.9 The second, more significant instance is the failure of mental health services 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. As noted above, this was contrary to the discharge policy then in place and the review panel was assured that this was not normal practice.
- 4.10 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 history, combined with the lack of review of the patient's mental health despite ongoing repeat prescriptions 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 in the notes to suggest any wider discussion of his mental health. The Individual GP Practice has subsequently implemented the recommendations from the IMR and has provided robust evidence that these have been actioned.
- 4.11 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.
- 4.12 In this particular case there was no risk identified and, therefore, no automatic right to share information within information sharing protocols or patient confidentiality processes. Unless information is shared and reviewed, however, it is not possible to ascertain the current mental state of a patient; the services they are, or are not, receiving; or the possibility of the need for additional support to access these in order to improve their health.
- 4.13 The two organisations concerned have identified these issues in their individual reports and have made specific recommendations relating to these:

- Black Country Partnership NHS Foundation Trust (Mental Health Services):

To ensure that discharges are appropriate, both for the patient's well-being and that of their family and the wider community, the DNA (did not attend) policy to be revised and re-launched and compliance monitored

- Sandwell and West Birmingham Clinical Commissioning Group:

The practice to review their repeat prescribing protocol in respect of antidepressant prescribing to include requirements for periodic medication review to ensure that the patient receives effective treatment.

The practice to receive training on record keeping and consider implementing templates to assist in consultations for those patients with mental health needs in order to ensure effective record keeping is in place and that the patient receives appropriate care.

- 4.14 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
- 4.15 It is further noted that, as of June 2013, of the 19 DHRs undertaken within the West Midlands Police Force area, 13 included issues apparently relating to mental health.

The Review, therefore, makes the following recommendation, which has already been implemented by NHS England:

That, in order to improve safe practice and patient care, the Safer Sandwell Partnership asks 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 GPs practices.

- 4.16 The panel considered the possibility of making a recommendation regarding the improved sharing of all findings and recommendations from such reviews across the various Boards and Partnerships, in order to maximise the benefits of any learning. On balance it was felt that a recommendation of this sort was wider than the remit of any individual review and it was also acknowledged that it would be extremely difficult to formulate. The panel would, however, suggest to the Partnership that discussions take place with other Partnerships and Boards to explore this possibility further.
[NB: Since drafting this report, a piece of research has been undertaken to collate and analyse lessons and recommendations from all DHRs across the West Midlands.]
- 4.17 This has been a difficult Review to undertake, both for the panel and for the individual report writers since, as noted within the main body of the report, little was known about the victim or the perpetrator and, therefore, many of the terms of reference were not applicable on this occasion.

- 4.18 As also noted above, the terms of reference for conducting a review assume that there have been previous concerns, or disclosure, of domestic abuse. This was not the case in this instance in relation to Adult 1.
- 4.19 The Review panel agrees that the threshold for holding the review as defined in the legislation was met, namely “the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by a person to whom he was related”⁴. 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 guidance⁵ was the most effective in this case.
- 4.20 The Panel is aware that the Home Office has recently revised the statutory guidance⁶. 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 review⁷.

The Review, therefore, makes the following recommendation:

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).

5. Additional information requested by the Home Office

- 5.1 In submitting a previous version of this report to the Home Office, they requested that common themes and issues that were also present in two other similar reviews recently submitted from Sandwell be identified and an assurance given that those common issues will be acted upon through a joined up approach by Sandwell Community Safety Partnership.
- 5.2 The DHR panel who undertook this review affirms that the Action Plan addresses the issues raised in the report, and the recommendations have been fully implemented. Since the statutory responsibility to carry out domestic homicide reviews which came into force in April 2011, Sandwell has

⁴ Domestic Violence, Crime and Victims Act 2004 S 9: 1(a)

⁵ Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews HO

⁶ Multi-Agency Statutory Guidance for the conduct of Domestic Homicide Reviews. Revised - applicable to all notifications made from and including 1 August 2013 HO

⁷ Working Together to Safeguard Children 2013: Reference: DFE-00030-2013

undertaken 4 domestic homicide reviews. The reviews have outlined a number of recommendations, common themes to the area and lessons learnt. A Domestic Homicide Review Standing Panel was established in December 2012 to oversee all of Sandwell's DHR cases and ensure that recommendations from DHRs are implemented and lessons learnt disseminated to partner agencies. The Standing Panel also ensures that a joined up approach is taken to identify common themes and lessons learnt. The DHR Standing Panel consists of statutory and voluntary organisations including: West Midlands Police, Probation Community Rehabilitation Company, National Probation Service, Health, Sandwell Women's Aid, Sandwell Council's Domestic Abuse Team, Adults Social Care and Safeguarding Team, and Children's Social Care. The DHR Standing Panel reports to the Domestic Abuse Strategic Partnership and Safer Sandwell Partnership Board. Two Learning Events have also taken place to disseminate the lessons learnt from DHRs and Serious Case Reviews. The events have been well attended with 200 people from various organisations including voluntary and statutory partner agency frontline officers and managers. Sandwell has also contributed to research undertaken by the University of Middlesex: - Preventing Domestic Violence and Abuse: Common Themes Lessons Learned from West Midlands DHRs.

- 5.3 A number of other sub groups have also been established by the Domestic Abuse Strategic Partnership partly in response to lessons learnt following DHRs. A Domestic Violence Campaign Group has developed an awareness campaign and is working to raise awareness of domestic abuse issues and support services available. A Learning and Development sub group has been set up to undertake a Training Needs Analysis on Domestic Abuse and provide recommendations to the DASP on the development and implementation of a Learning and Development strategy/plan. A Quality and Audit sub group has also been established to ensure that partner organisations have effective protocols and procedures in place to ensure victims of domestic abuse and their families are being effectively safeguarded in Sandwell and work with domestic abuse perpetrators is effective.