The Solihull Partnership
Safer Solihull
Local Police and Crime Board
Involving local people in keeping Solihull safe

# Domestic Homicide Review under section 9 of the Domestic Violence Crime and Victims Act 2004

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## In respect of the death of a woman

**Report produced by Gill Baker OBE. BA (Hons)**

**Independent Chair and Author**

**July 2017**

**GLOSSARY**

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| ADHD | Attention Deficit Hyperactivity Disorder |
| CAMHS | Child & Adolescent Mental Health Service |
| EBD | Education Behaviour Disorder |
| DHR | Domestic Homicide Review |
| GP | General Practitioner |
| IBP | Individual Behaviour Programme |
| IAPT | Improving Access to Psychological Therapy |
| IMR | Individual Management Review |
| ISA | Information Sharing Agreement |
| LDA | Learning Disability Assessment |
| LSCB | Local Safeguarding Children Board |
| ODD | Oppositional Defiant Disorder |
| PA | Personal Advisor (Connexions Service) |
| PE | Physical Education |
| PRU | Pupil Referral Unit |
| SEN | Special Educational Needs |
| YISP | Youth Inclusion Support & Prevention |

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# 1. Introduction

1.1 In June 2015 police officers from West Midlands Police attended an incident whereby it was reported that two men were fighting. On arrival the officers found the Woman, subject of this review. She was lying on the driveway of her home and her son was also at the scene. Both had been assaulted, had sustained serious injury and were taken to hospital. The offender, who is a nephew of the Woman, was found nearby by police officers. He was bare chested and was in an agitated state chanting to himself. He was arrested on suspicion of assault and was also taken to hospital. The Woman died shortly after arriving at hospital as a result of the injuries she had sustained and her son survived. The offender was further arrested on suspicion of murder and whilst in custody was assessed under the Mental Health Act when he was deemed fit to be detained and interviewed. He was later charged and convicted of the manslaughter of the Woman and of causing grievous bodily harm to her son.

1.2 Subsequently, on the 25 July 2015, the Safer Solihull Partnership reviewed the circumstances of this case against the criteria set out in the Multi Agency Statutory Guidance for the conduct of Domestic Homicide Reviews. It was concluded that a Domestic Homicide Review (DHR) should commence as there were lessons to be learnt as this case met the following criteria:

*Domestic Violence, Crimes and Victims Act (2004) Section 9(3)*

*Requires that a domestic homicide review be undertaken in circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by-*

*a person to whom s/he was related or with whom s/he was or had been in in intimate relationship, or*

*a member of the same household as her/himself, held with a view to identifying the lessons to be learnt from the death*

## 2. Purpose, Scope and Terms of Reference

2.1 The purpose of this Domestic Homicide Review is as outlined in government document *Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews'*. The aim being to:

- *Establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims;*
- *Identify clearly what the those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result;*
- *Apply these lessons to service responses including changes to the policies and procedures as appropriate; and*
- *Prevent domestic homicide and improve service responses for all domestic violence victims and their children through improved intra and inter-agency working,*

2.2 It was determined that this review should focus on events from 1 October 2004, and it should include contact with extended members of the family and any other significant persons only in so much as it is relevant to the decision making and safeguarding of the Woman. However it was stipulated that should agencies identify information from an earlier date which is relevant to the findings of the Domestic Homicide Review then that should be included. In addition further information prior to that date would be requested by the Domestic Homicide Review panel if it the relevance became evident.

2.3 The issues to be addressed by agencies, in trying to learn from this case were identified in the Terms of Reference as:

- *To establish whether it was known, or could have been suspected that the offender posed a risk of harm to the Woman or her son and whether any*

*action could have been taken to prevent the homicide. To establish, therefore, whether the homicide was predictable or preventable.*

- *To identify how effective agencies were in identifying the risk of harm that the alleged offender posed, and how such risks were managed if identified.*

- *To establish how well agencies work together and to identify any gaps and/or changes that are required to strengthen inter-agency working; commissioning, practice; policies; and or procedures to improve the identification and protection of people subject to risk of harm within Solihull.*

***Key lines of enquiry*.**

*1: What knowledge did your agency have that indicated that the Woman might be a victim and her nephew an alleged offender of domestic homicide and how did your agency respond to this information?*

*In considering the response, think about:*

- *What was known by agencies about the alleged offender? Include your understanding of potential risks and how they were managed?*
- *Were practitioners aware of and sensitive to the needs of the victim in their work and knowledgeable both about potential indicators of harm, abuse or neglect and about what to do if they had concerns about a victim's welfare?*
- *Did the organisation have in place policies and procedures for domestic abuse, safeguarding and promoting the welfare of victims and acting on concerns about their welfare and any disclosures?*
- *What were the key relevant points/opportunities and decision making in this case in relation to the victims and family? Do assessments and decisions appear to have been reached in an informed and professional way?*
- *Did actions accord with assessments and decisions made? Were appropriate services offered/provided or relevant enquiries made, in the light of assessments?*

- *How, when and why did your agency share information with others and what was the impact?*
- *Was the supervision and management of the case in your agency effective and did it follow agency (and inter-agency) policies and procedures?*
- *Did agencies disclose any risk of harm to the victim/s?*
- *To what degree did the victims' understanding of the risk of harm impact on decision making of the victim and agencies, if known?*
- *Should the information known have led to a different response?*
- *Was it reasonably possible, with the benefit of hindsight, to predict, and work to prevent, the domestic homicide subsequently suffered?*

*2: What services did your agency offer to the victims? In considering the response, think about:*

- *Were appropriate services offered or provided or relevant enquiries made in the light of assessments?*
- *Were they accessible; appropriate; empowering and empathetic to their needs?*
- *Were practitioners sensitive to the needs of the victims?*
- *Were procedures sensitive to their ethnic; cultural; linguistic; and religious identity and was consideration for vulnerability or disability necessary?*
- *When and in what way were the victims' wishes and feelings ascertained and considered?*
- *Were the victims informed of options and choices and supported to make informed decisions?*
- *Were there identified needs unmet or needs which conflicted with the needs of others?*

*3: Were there issues in relation to capacity or resources in your agency that impacted on the ability of the agency to provide services (to the victims, alleged offender or any family member) or which impacted on the agency's ability to work effectively with others?*

*In considering the response, think about:*

- *Was there an adequate number of staff in post? Did any resourcing issues such as vacant posts or staff sick leave have an impact on the case?*
- *Was there sufficient management accountability for decision making?*
- *Were there any issues, in communication, information sharing or service delivery, between those with responsibilities for work during normal office hours and others providing out of office services, particularly for Police, Health Services and the Local Authority?*

## 3. Process

3.1 Notification of this review was sent to agencies who were asked to undertake an Individual Management Review (IMR) of any contact with the Woman and the offender. The agencies were requested to look critically and openly at individual and organisational practice to ascertain whether changes could and should be made and, if so, how this should be achieved. It was requested that a senior member of staff who had no involvement with the case, complete the individual management review. Guidance notes which included a template for the review report were provided to each agency. It was requested that upon completion, each Individual Management Review be agreed by that organisation's senior managers who would be responsible for ensuring that their single agency recommendations are acted upon. If agencies had no contact with the woman or offender they were asked to complete a 'nil' return. Those agencies which had minimal involvement provided an information report.

3.2 A Domestic Homicide Review panel was established to actively manage the review processes and to obtain all relevant information from agencies and any parallel processes. The panel's role was to ensure robust analysis of IMRs and that the overview report accurately reflected agency contributions and met the Domestic Homicide Review guidance. The panel was set up with an

Independent Chair/Author and representatives from a range of agencies relevant to this case.

3.5 Upon receipt of Individual Management Reviews from agencies, a composite chronology of events was produced. The Individual Management Reviews and integrated chronology were discussed by the review panel and any discrepancies or need for further information was resolved by either written or verbal communication. As a result amended final Individual Management Reviews were received from the agencies as indicated in paragraph 5.

3.6 The Review Panel met on nine occasions to consider all of the Individual Management Reviews, information reports and to progress the Overview Report.

3.7 The Overview Report was presented to and agreed by the Safer Solihull Partnership on 26 April 2017.

## 4. Domestic Homicide Review Panel Members

4.1 **Independent Chair/Author** Gill Baker OBE

The chair and author of the overview report is a retired police officer who is independent of all the local agencies and professionals involved in the case and of the Safer Solihull Partnership. During the last ten years of her thirty year police service she was a Detective Inspector specialising in child protection, domestic violence, sexual offences, sex offender management and vulnerable adult protection. Within her role she was responsible for compiling police individual management reviews and was a member of many serious case review panels across the West Midlands area. She was involved in the development of local, national and international multi-agency projects and initiatives as well as policy and procedures for the police service. Her work in this field was recognised when she was awarded an OBE in 2006 for services to the police. Since retirement in 2005 she has been independent chair and/or

author of several serious case reviews, domestic homicide reviews and Multi Agency Public Protection Arrangements (MAPPA) reviews.

4.2 The members of the panel are senior managers from the key statutory agencies who had no direct contact or management involvement with the case and were not the authors of individual management reviews.

4.3 **Panel Members:**

- Detective Chief Inspector – West Midlands Police
- Deputy Director of Nursing and Quality -Birmingham & Solihull Mental Health Foundation Trust
- Domestic Abuse Co-ordinator – Solihull Metropolitan Borough Council
- Community Safety Manager – Solihull Metropolitan Borough Council
- Head of Coventry & Solihull Community Rehabilitation Company
- Joint Strategic Commissioner Mental Health -Solihull Metropolitan Borough Council
- Head of Safeguarding/Designated Nurse -Solihull Clinical Commissioning Group

## 5 Individual Management Reviews

5.1 Agencies were asked to provide an Individual Management Reviews, an information report or a nil return, if they had had no contact with the woman and/or the perpetrator. As a result Individual Management Reviews were received from the following agencies:

- Birmingham & Solihull Mental Health Foundation Trust
- Heart of England NHS Foundation Trust

- Solihull Clinical Commissioning Group (on behalf of 2 member GP practices)
- Solihull Metropolitan Borough Council – Education Department
- West Midlands Police

5.2 **Information Reports**

Due to a lesser involvement with the woman and the offender, information reports were obtained from the following agencies:

- Connexions
- Talent Match (Birmingham Voluntary Service Council)
- Solihull Healthy Minds
- Solihull MIND
- West Midlands Ambulance Service NHS Foundation Trust
- Warwickshire Police

**5.3 Reviews/ Independent Management information Reports**

**Process**

Agencies reviewed their computer and paper records, details of which are itemised within their respective Individual Management Reviews . Each of the agencies conducted interviews of their staff to enhance the quality of their Individual Management Review and to try and get an understanding of not only what happened but why something did or did not happen. Contextual information relating to volume of work, staff turnover, training, sickness, organisational change management and supervisory practice is contained within each Individual Management Review.

5.4 The Panel robustly scrutinised and quality assured each Individual Management Reviews and information report. Specific issues in written form were raised with each of the Individual Management Reviews authors, which

resulted in amendments and additions. There was some considerable delay in obtaining full information in respect of the Education Individual Management Reviews which was in the main due to reluctance by a secondary school to provide information. This particular school is now an Academy but during the relevant time period was under the governance of the local authority. Information was eventually found contained within inter-disciplinary local authority education files. The final Individual Management Reviews received from education was of a good standard with comprehensive information, analysis and internal recommendations. However of concern is the reluctance of the Academy to provide information without either a court order or the consent of the offender. When seen by the Domestic Homicide Review chair/Author and a member of the Domestic Homicide Review panel, the offender gave written consent for release of information. Despite having obtained this consent the Academy then reported an inability to find any records in respect of the offender It is the view of the Domestic Homicide Review panel that this could prove to be a difficulty not only locally but nationally in view of the fact that Academies, as well as Free Schools and Independent Schools, are not bound by statute to participate in the Domestic Homicide Review process and hence a national recommendation is suggested as follows:

**RECOMMENDATION 1**

**The Home Office issue guidance to schools (Academies, Free Schools or Independent Schools) not under the governance of a Local Authority in respect of participation and release of information for the purpose of Domestic Homicide Reviews.**

5.5 A total of ten single agency recommendations were contained in the Individual Management Reviews which were scrutinised by the panel and are considered appropriate and any shortfalls considered by the panel were included in the overview recommendations. Agencies were requested to progress their single agency recommendations in a timely manner prior to the publication of the domestic homicide review.

## 6. Ethnicity, Diversity and Cultural Issues

6.1 Commissioning arrangements for Individual Management Review reports required agencies to specifically consider whether practice was sensitive to racial, cultural, disability, linguistic and religious identity of the subjects of the domestic homicide review, and the impact on service delivery.

6.2 Solihull is a broadly affluent borough in both the regional and national context, characterised by above-average levels of income and home ownership and a high proportion of residents (50%) classified as belonging to the Prosperous Suburbs socio-demographic classification. The Office for National Statistics (ONS)[1] estimates that Solihull's resident population was 210,445 in 2015, 19.1% were estimated to be under 16 years, 60.1% aged between 16 and 64 years and 20.9% aged over 65 years. In the 2011 Census 85.8% of residents were White British, compared with the national average in England and Wales of 79.8% .

6.3 Section 149 of the Equality Act 2010 introduced a public sector duty which is incumbent upon all organisations participating in this review, namely to:

- eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under this Act;
- advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it;
- foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

6.4 The review gave due consideration to each of the protected characteristics under the Equality Act 2010, paying particular attention to mental health.

[1] Source ONS Mid-2015 population estimates

## 7. Background

7.1 The offender was born in **1990** and initially resided with his mother and the Woman who was his paternal aunt. The relationship between his mother and birth father had broken down whilst his mother was pregnant but there was regular contact between the offender and his birth father. Approximately a year after his birth the offender and his mother moved into their own accommodation. The offender's mother married when he was around 4 years of age. He got on well with his step father who had two children of his own and they all lived together but the marriage broke down. The offender was quite upset at the time and his mother stated that it was around then that he was diagnosed with Attention Deficit Hyperactivity Disorder (ADHD). The Woman and the offender had a close relationship and she always provided support, emotionally and on a few occasions financially, to the offender and his mother. The Woman was a retired deputy head teacher and was able to advise and support the offender during his school life and attended meetings with his mother at the schools he attended when his behaviour and lack of educational progression was causing concern.

7.2. The Woman lived with her son and the offender would be a regular visitor, sometimes staying overnight, and she often found him casual work, such as gardening in the area where she lived. It is known that when the offender needed help or advice that he would turn to the Woman for guidance and reassurance. It is believed that just prior to the death of the Woman he had asked if he could live with her and her son.

## 8. Chronological Sequence of Events

8.1 Each agency was required to collate a sequence of events of their organisation's professional involvement with the family and this information was merged to create an integrated chronology to enhance learning. Significant events from the birth of the offender are outlined as follows:

8.2 The offender started infant school in **1995** and it is recorded that he was a regular attender but was placed on the Special Educational Needs register with stage 1 intervention to improve reading and writing skills. It was noted that he lacked concentration and was easily upset by perceived errors. In **1998**, aged 7 years he transferred to a junior school when his behaviour, described as 'violent outbursts', began to give rise to concern and hence in **June 1999** there was an initial meeting between an educational psychologist and the offender's mother. It is recorded that the offender was '*aggressive towards other children and his learning was of some concern, particularly spelling, self-esteem and confidence'.* A staged behaviour plan was implemented and the offender, aged 8 years, was placed on school action plus of Special Educational Needs (SEN) code of practice. From this time he was regularly seen by an educational psychologist. Regular 'Stage 3' Reviews were held at the school regarding the offender and present usually were the head teacher, class teacher, educational psychologist, special educational needs Co-ordinator (SENCO), the offender's mother and on occasion the offender's birth father.

8.3 It was recorded within a stage 3 review at his school that *'he had a competitive nature and problems occur, particularly during games when he felt that his team were not winning'.* Also recorded was that the offender was *'self-critical and will not readily make a fool of himself – if in doubt, he refuses to do what has been requested of him'.* The offender's behaviour continued to raise concern and in **September 2001** an Individual Behaviour Programme Plan (IBP) was formulated in an effort to manage his behaviour. The main behaviours causing problems were:

- *calling out in class*
- *aggressive manner*
- *temper – losing control*
- *swearing and being rude to staff*
- *distracting others*

In **November 2001,** the Head teacher of the school also requested support from the Learning Support Service citing the fact that the offender *'loses his*

*temper and becomes very aggressive, lashing out and deliberately trying to hurt other children'.* In the opinion of the head teacher it was felt that *'it is only a matter of time before he does serious damage to someone'.* In view of the fact that the flashpoint often occurred during games sessions, the offender had been stopped from taking part in all physical education (PE) apart from swimming.

8.4 In **December 2001** a Consultant Psychiatrist from Solihull Primary Care Trust Child & Adolescent Mental Health Service (CAMHS) attended a Stage 3 Review in respect of the offender, who was then aged 11 years. It was explained that the offender had started to take a slow release of Ritalin, as from in **November 2001** after being diagnosed as suffering from Attention Deficit Hyperactivity Disorder (ADHD). It was felt that the offender's behaviour had shown improvement and he seemed somewhat calmer. The offender's mother stated that he did not take the medication at weekends as she and the offender's birth father found that there was no need. It was noted at this meeting that the offender did not engage well with the Consultant Psychiatrist and discussion took place about his academic performance. There was a representative from the Educational Behaviour Disorder team at the meeting and the involvement of that service was welcomed by the Consultant Psychiatrist particularly in view of the offender's unwillingness to engage with Child & Adolescent Mental Health Service.

8.5 The behaviour of the offender at school continued to be of concern despite the specialist intervention from the Educational Behaviour Disorder team. At a meeting in **December 2001** the possibility of moving to stage 4 (a statement of special educational needs) was discussed when it was reported that the offender had kicked a girl hard, had sworn at the class and at the class teacher. After leaving the classroom he had punched and banged his head against a wall. Other instances of aggressive behaviour including assaults against other children were also discussed. Despite a strong case being put forward by the school, this was opposed by the Educational Behaviour Disorder service with a request for further intervention which was agreed.

Hence the offender was not moved to stage 4 despite this being raised as a possibility again in **March 2002**. The offender was allowed to leave junior school a week early due to behaviour concerns. This was an agreement between the school and the offender's mother.

8.6 In **September 2002** the offender, aged 11 years became a pupil at a secondary school.

**Note:** ***The secondary school (now an Academy) have been unable to provide any records concerning the offender and hence unknown is exactly what information was shared between the schools. However records kept by the educational psychology service have been available which detail the behaviour of the offender.***

8.7 In **April 2005** a case summary was prepared by the Educational Psychology Service following a request for a Statutory Assessment in respect of the offender. This request followed an incident at the school when the offender threatened to kill his female Technology teacher, his attempt to physically assault her and the accompanying verbal abuse which he subjected the teacher to. Within the case summary it was stated that input had been provided consistently by the Learning Support Service Education Behaviour Disorder team with mental health input from the Child & Adolescent Mental Health Service. Support measures and interventions consisted of:

- **Pastoral Support** – high level of guidance on a day-to-day basis by form teacher
- Education Behaviour Disorder **Outreach** – included an intensive anger management course along with discussion about specific incidents, analysing their causes, and strategies for managing his behaviour.
- **Pupil Referral Unit (PRU) placement** – the offender (aged 13) attended a 4 week intensive placement with the intention to help improve his self-esteem in relation to skills and abilities, work on anger management and improve ways of managing relationships. A report

made at the end of this placement indicated that the offender had achieved well in all aspects of the programme.

- **Pupil Referral Unit in school support** – this took place on a weekly basis with the intention of re-integrating the offender and review progress.
- **Blue Card** – scheme intended to help the offender with behaviour self - management but his temper outbursts were such that he did not or could not use the card in time.
- **Child & Adolescent Mental Health Service.** – Educational Psychology were aware of inputs from this service but in **March 2003** were informed that the offender (then aged 12 years) was *'extremely unwilling to attend the clinic and refuses to speak with the Consultant Psychiatrist who felt that in the circumstances no useful therapeutic work could be done with him'.* Also it was understood by Educational Psychology from information given by the offender's mother. That in **March 2005** a further assessment took place when the offender's problems were adjudged to be educational and hence there was no further action by the Child and Family unit. However, during this Domestic Homicide review it has been discovered that in **February 2005,** the offender's mother had raised concerns with the GP about her son following his behaviour at school and an exclusion from school for 2 days. As a result the GP restarted the Ritalin medication and made a referral to Child & Adolescent Mental Health Service in respect of the offender and also requested support for his mother. The offender was seen by a Psychiatrist in **March 2005** when it was noted that the angry outbursts seemed to be attributed to pressure at school and the offender's mother was asked to liaise with the school and discuss whether the statement of educational needs should be reassessed and recommenced and should explore what sort of anger management they were offering. The file was kept open until the family returned with the information. The GP and the offender's mother were written to about what had been agreed at the appointment. The offender was again suspended from school and saw the GP again when he was prescribed

Concerta XL medication. Information was exchanged between the GP and the Psychiatrist and the offender and his mother saw the psychiatrist again in **April 2005.** The incident that led to his suspension from school was discussed but the offender was noted to be withdrawn with his mother speaking on his behalf. The involvement of the educational psychological service was noted and the psychiatrist felt that a psychiatric assessment would be appropriate as 'anger management may not provide the right environment for the offender to discuss how he was feeling'. Previous notes indicated that the offender had been diagnosed with Attention Deficit Hyperactivity Disorder and that he was clumsy and had symptoms that would fit with Oppositional Defiant Disorder (ODD). Ten days later **the** offender and his mother were again seen by the psychiatrist when it was recorded in the notes that "the medication had no discernible benefit to the offender". It was also noted that his mother gave the medication to her son based on her observations; she did not give him any medication at weekends as she did not feel it necessary when he was not at school. The offender's mother was not convinced about how worthwhile the appointments with psychiatry would be and stated that if medication was all that was on offer she would rather get it from the GP. However, a further review appointment was made.

- **Educational Psychological Service –** input had been provided to the offender whilst at junior school but no formal referral to this service was made whilst the offender was at secondary school because of the support being given within the school.

Within the case summary report (complied by the Educational Psychology Service) listed were event logs from early **February 2003** until mid-**April 2005**. It was noted that several other event log entries were lost on transfer to a new system. Nevertheless 20 incidents are recorded whereby the offender had been in conflict with other pupils; there were threats of violence, physical assaults, swearing and racist abuse. There were complaints from parents of other pupils as they were concerned about the safety of their children. During

some of the outbursts the offender would throw things, kick walls, doors and furniture. He also was aggressive towards teachers who intervened, swearing and threatening violence towards them. The offender was excluded from school for 2 days in January 2005 and for 4 days in March 2005. His behaviour culminated in the serious incident of violence when he threatened to kill a teacher.

8.8 The conclusion and the opinion of the Assistant Principal Educational Psychologist at the conclusion of the case summary, was that the offender:

*'has been displaying emotional, social and behavioural difficulties for the last six years. This has posed a significant management challenge for his mother and for his primary and secondary schools. Despite intervention from all appropriate agencies and schools, his difficulties remain and, indeed, have escalated to the point where staff are unable to cope with his behaviour without extensive support and input. He is also posing a risk to staff and other pupils with his aggressive behaviour'.*

The request for a Statutory Assessment was supported by the educational psychology service as it was felt that the offender would benefit from an alternative placement.

8.9 In early **May 2005** the offender was permanently excluded from the secondary school, a decision made by the head teacher which was upheld by the school's governing body in mid **May 2005**. The offender was referred to the Pupil Referral Unit where he had previously attended and assessments took place in order to identify a provision which could meet his needs. The offender had a further two appointments with the psychiatrist and also saw the GP again when medication was reviewed. It was noted that the offender's mother was sceptical about the benefit of medication which she was giving intermittently and not as advised. She was advised of the correct administration of the medication in line with prescribed doses.

8.10 In early **September 2005** the offender, aged 14 years, started at a special school in order to continue his education. Initially the offender seemed to settle well into the school where he benefitted from more one to one attention with a higher teacher to pupil ratio. It was decided by Solihull Education & Children's Directorate to undertake a statutory assessment under Section 323 of the Education Act 1996. As part of the assessment information was sought from the offender's parents, the school, Child & Adolescent Mental Health Service, Educational Psychology Service and Education Welfare Service.

8.11 The offender was seen by the psychiatrist in early **January 2006** for a review when it was noted that he was doing well and on course to attain his GCSEs. The medication prescribed by the GP was reviewed and the dosage had been reduced. The offender was found to be in a good mood and talking more than normal. It is recorded that the offender's mother asked for him to be discharged as they *'had seen several psychiatrists and knew what the diagnosis was. They were very happy to be reviewed by the GP and to avoid coming to reviews that disrupted work and school'.*

8.12 In late **January 2006** the offender was allocated to a Connexions Service personal advisor (PA) with the purpose of supporting him with his career ideas and post 16 transition from school.

8.13 In late **February 2006,** a statement of Special Education Needs was finalised in respect of the offender. This summarised that the Local Education Authority regarded his needs as severe and complex and requiring special provision for: Emotional, Social and Behavioural Difficulties. The objectives of the statement were for the offender to:

- Develop age appropriate spelling skills
- To continue to develop his reading accuracy and comprehension skills
- To develop his ability to focus his attention on tasks
- To learn to establish and sustain appropriate relationships with his peers and with adults

- To develop his self confidence and self-esteem

8.14 However the offender's disruptive behaviour continued and he received ten fixed term (1, 2, 3 or 5 day) exclusions for physical assaults on either pupils or teachers. The first occasion was in early **March 2006.** As well as assaulting others he would self-harm and it was noted that when anxious distressed or emotional the offender would often punch walls with enough force to hurt himself. It is not known whether he caused any injury to others.

8.15 In **September 2006** the offender was seen by a psychologist at Counselling & Psychology services. This was as a result of the offender's mother expressing concern about his violent outbursts and exclusions from school**.** She was particularly concerned about his behaviour because he was approaching school leaving age and she felt his outbursts could lead to trouble with the police. It was established that he was receiving help with anger management via the school and reported a positive relationship with the person leading this intervention. It was noted that he was uncomfortable discussing his problems and struggled to maintain eye contact.

8.16 Following a physical assault on a teacher which occurred in mid-**December 2006,** an emergency review of the offender's Statement of Special Educational Needs took place in early **January 2007**. The school hoped to find a way forward to enable him to complete his school year and GCSE examinations. It was noted in the review that the offender's *'unpredictable, violent outbursts are of great concern. It is important in supporting him that all pupils and adults in the school are kept safe and feel that they are safe'.* Present at this review meeting was the offender's mother and his aunt (the Woman subject of this review). It was stated that additional support was needed to provide one to one provision for the offender but it is unclear how this was to be achieved. It also appears that a referral was made from the school to Child & Adolescent Mental Health Service.

8.17 Despite arrangements for further appointments with the psychologist the records stated that the offender failed to attend and in mid-March **2007** the offender was discharged from the service. The psychologist wrote to the GP stating that he had declined to attend appointments and seemed more comfortable with the person providing anger management support.

8.18 In late **June 2007** the offender, aged 16, left school after taking his GCSE examinations. He was still subject of the Statement of Special Educational Needs which continued when he started an engineering course at a college. He had been successful in his GCSE examinations. The statement of Special Educational Needs ceased in early **August 2008** and he left college, aged 18 years, in **June 2009** after successfully completing the engineering course and attaining a First certificate in engineering.

**Note: Unfortunately no records are available which give any indication of behaviour and interaction with others whilst at college.**

8.19 However during the time that the offender was undertaking his college course, he first came to the notice of the police. In **August 2008,** aged 17 years the offender was arrested after he punched an adult male in the face causing injury of a bloody nose and cut to the lip. This occurred after a disagreement at a bus stop. The offender admitted the offence, expressed remorse and received a caution. From records available it is not known whether the offender knew his victim prior to the assault.

8.20 In early **January 2010,** aged 19 years**,** the offender saw his GP and reported feeling low and was quite upset but was unwilling to be specific. He stated he felt depressed some of the time and thought that he needed counselling. The offender was given details of Solihull MIND, an organisation which could offer support. He was encouraged to think things over and return to the GP if he wanted to discuss further. In early **March 2010** the offender, together with his mother, again saw the GP. He was in low mood, had lost confidence because he was unable to gain an apprenticeship and worried that he would get into trouble because of his frustrations. He also stated that he had thought about self-harming. He was prescribed Citalopram, an anti-depressant medication.

8.21 In early **April 2010,** a member of the public reported that some people were smoking cannabis on a bus. Police officers attended and spoke with the offender who was in possession of a small amount of herbal cannabis. He was issued with a street caution for possession of cannabis.

8.22 In mid-April **2010** the offender again saw his GP when he stated that he felt no real benefit from the medication and that he hated feeling angry all of the time. He mentioned that he had been sacked from his job. He also had tender swelling to his right hand. The GP made a referral for a primary care mental health assessment and also for an x ray regarding the injury to his hand. The same day the offender attended the Accident Emergency Department at a hospital when it was found that he had fracture and the degree of deformity indicated that there had been previously healed fractures. The offender confirmed multiple punch injuries previously which he had not sought treatment for.

8.23 In **December 2010,** aged 20 years, the offender was arrested by officers from Warwickshire Police after an incident whilst at the home address of his birth father and step mother. Police officers attended and found the offender being restrained by his birth father in the hallway of the house. They were separated and the offender's step mother alleged that she and the offender had had a verbal disagreement which escalated to him getting a kitchen knife and holding it to her neck and drawing it across her neck and shoulders. There was no visible injury. It was recorded that the offender, his birth father and his step mother had all consumed alcohol. The offender was arrested and upon interview admitted the assault and it is noted that he was visibly upset during the interview. His step mother declined to pursue a complaint and hence the offender received a caution for common assault. It was noted that he had no previous convictions or cautions and hence his previous caution for common assault, albeit in another police area, was missed. A Domestic Abuse, Stalking and Honour Based Violence (DASH) risk assessment completed by the attending officer assessed the risk as standard but this was later revised to a medium risk by the specialist PVP (Protecting Vulnerable People) Referrals & Assessment Unit on the basis that there were

'*identifiable indicators of risk of serious harm; the offender has the potential to cause serious harm but is unlikely to do so unless there is a change in circumstances'.* As the offender lived in West Midlands Police area details of the incident were shared via an email.

8.24 In **March 2011** the offender was arrested for being drunk and disorderly in a bar. It was reported that he had been arguing with door staff and when police officers arrived he became aggressive and attempted to assault one of the officers. Upon arrival at the police station custody suite, the offender was deemed to be drunk and again became aggressive towards the custody officer. In relation to this offence he was issued with a Fixed Penalty notice.

8.25 The offender had his last contact with the Connexions Service Personal adviser in late **March 2011.** Whilst at the special school the Personal adviser had 27 contacts with the offender to assist his post 16 transition. To assist with the transition a Learning Disability Assessment (LDA) also known as a Section 140 was produced in April 2007 and a copy sent to the offender's mother. A further 13 contacts were made with the offender while he made the transition from special school to college and while at the college. Another 7 contacts were made after the offender had left college and it was established that he had a temporary job at a warehouse and was doing a casual gardening job. In September 2010 the Personal adviser was informed that the offender had undergone constructive surgery on his ankle. A further 4 contacts were made with the offender after that date and eleven e-mails sent with information about opportunities. The case was closed due to a loss of engagement with the offender and his age (21 years). The Connexions remit was to work with young people, aged 15 to 18 years, and up to 21 years if the young person had special needs.

8.26 In **September 2011,** aged 20 years**,** the offender was arrested and charged with assault. He had been out drinking and was travelling in a taxi with another adult male when he became racially abusive towards the other male passenger and punched him in the face. The offender was found to be under the influence of alcohol and suspected of also being under the influence of

drugs. A healthcare professional examined him and he was found fit to be detained. The offender denied the offence and was charged with common assault. In **October 2011** he pleaded guilty and was fined.

8.27 In **March 2013,** aged 22 years, a taxi driver reported an incident concerning the offender where he had disputed the taxi fare. An argument ensued and the offender became aggressive towards the taxi driver who feared that he may be assaulted as the offender had chased after the taxi. The taxi driver wanted the police to speak with the offender but did not want the matter to go to court. This incident was recorded as a public order offence and the offender was seen and apologised for his actions. The matter was dealt with by way of a Community Resolution.

8.28 In mid-June **2013** the offender saw his GP and reported that he had felt suicidal the day before when he thought about cutting himself. He felt '*like no point in him being there'*, and felt that way on a daily basis. He denied hearing any voices or hallucinating and was not feeling suicidal at the time of the appointment. He reported that he was working in a bar but had got suspended recently for pushing someone. He denied alcohol intake but admitted to smoking cannabis twice a day as it '*helps him sleep and makes the day bearable'.* He denied any other substance misuse. The GP made an urgent referral to the Solihull Community Mental Health Team for a review. Advice was given to the offender about action to take if he felt suicidal/low in mood in the future, (i.e. go to Hospital A&E), and to return to the GP if any problems.

8.29 Ten days later the offender, aged 22 years, was assessed by a nurse at a mental health clinic and was accepted for treatment. He was subsequently seen by a Community Mental Health Psychiatrist who diagnosed the offender as suffering from a mild depressive episode with symptoms of low mood, suicidal thoughts, irritability and anger. He was advised to take anti-depressants but refused medication and was referred for psychological treatment. The offender was seen on six occasions (between July 2013 and May 2015) by the Solihull Community Mental Health team when no symptoms of psychotic illness were noted. He is described as continuing to suffer from

mild depressive symptoms and continually made mention of his anger and irritability. Throughout this period he was advised to take anti-depressants which he took intermittently. Following a failure to attend in mid **July 2014** he was discharged from the Community Mental Health out patient service but not from the psychology service.

8.30 Between **August 2013** and **June 2014,** the offender was seen by GPs at the GP practice. He was prescribed Mirtazpine an anti-depressant medication, which he was reluctant to take as he was resentful of being given medication as a child and felt that he should receive therapy before taking medication.

8.31 The offender was assessed by a psychologist in **September 2013** and **in early September 2013** and was subsequently placed on a waiting list for psychological therapy. He remained on the waiting list for four months and when he obtained a place he attended 16 sessions ending on **6 November 2014.** During these sessions he discussed his anxiety, low mood, social isolation, fear of acting violently and his difficulty in trusting people. He disclosed also several occasions when he had acted violently. It is recorded that he said *'he wants to stop feeling angry, and worries about being violent towards people, sometimes strangers if he goes out'.* He also stated that he was anxious about going out unless he had smoked cannabis. He described some of the incidents such as the one involving his step mother but others which do not appear to have been known by any other agency. There was no contact with other agencies, such as the police, in respect of his disclosure of violent acts upon others. It was considered that there were no specific and immediate concerns to individuals or members of the public. Also it has been recorded during interviews with mental health practitioners during the course of this Domestic Homicide Review that previous experience of contacting the police for information had met with a poor response. In addition, whilst a referral for a forensic psychiatric assessment of the offender was considered and discussed, it was felt that the criteria were not met for such a referral.

8.32 During the period when he was receiving psychological counselling the offender was encouraged and supported to explore educational and

volunteering opportunities. In **July 2014** the offender made a visit to the Employment Development officer at Solihull MIND when guidance was sought for something interesting to do in an environment where he would be supported and understood and not judged for his mental health difficulties. Advice was given and he was signposted to a college to explore an Access course. In **September 2014** he accessed a pre-employment programme called Talent Match which works with 18-24 year olds in Birmingham & Solihull. A number of volunteering options were explored with the offender and he was then responsible for deciding upon which opportunity he wished to pursue.

8.33 The offender continued to regularly visit his GP who was notified that in **December 2014** the offender had been discharged from the Birmingham & Solihull Mental Health Trust as he failed to attend a review appointment in **December 2014.** Information was contained in the letter about support that the offender could seek in addressing anger management issues.

8.34 In **March 2015**, after expressing an interest in history, the offender secured a volunteer placement at a museum via the Talent Match scheme, and he did disclose information in relation to his mental health and wellbeing but confirmed that this was being addressed by his psychiatrist. With his permission contact was made by Talent Match and information was exchanged which resulted in no cause for concern.

8.35 In **June 2015** the offender informed Solihull MIND that the Access Course at the college had not worked out as he had hoped and he asked for an appointment to gain new direction. An appointment was made for mid-June 2015.

8.36 In early **June 2015** the offender saw his GP and discussed still feeling anxious, in low mood with poor concentration and interrupted sleep. It was noted that he was still engaged with the Talent Match scheme to undertake volunteering work, but the GP found difficulty in obtaining any other meaningful history. It was noted by the GP that 'he seems to be asking for help'. He was given contact details of Solihull Healthy Minds (Improving

Access to Psychological Therapies) where he could ask for support. He was also referred to hospital urology department due to a problem with urination. The offender telephoned Solihull Healthy Minds and made a self-referral and a telephone triage appointment was booked for mid-June 2015.

8.37 In early **June 2015** the offender was at the museum and had been sitting with fellow volunteers when he suddenly started laughing. When asked what he had found funny he said it was the '*way they were talking to each other'.* He then began rocking back and forward. He said he felt '*psychotic and schizophrenic and that his family didn't like him'.* He then hit his head on the table. In view of this a telephone call was made to Talent Match and a message was left expressing concern about his mental state. The message was not picked up until the following day when it was agreed that Talent Match would make contact with the offender.

8.38 In early **June 2015** the offender attacked the Woman and her son. The Woman died as a result of her injuries and her son sustained serious injury. The offender was arrested and a criminal investigation commenced.

## 9 Criminal Investigation and Parallel Investigations

9.1 In late May 2016 the offender, after pleading guilty on the grounds of diminished responsibility, was sentenced to life imprisonment for the manslaughter of the Woman and for causing grievous bodily harm to her son. The court heard of the ferocity of the attack on both the Woman and her son which resulted in numerous injuries to both. The court heard that after his arrest the offender had been diagnosed as a paranoid schizophrenic and at the time of the attack was suffering an episode of psychosis. He was sentenced to be detained in a secure mental health hospital (under Section 37 of the Mental Health Act 1983) and was to serve a minimum of nine years imprisonment. A Restriction Order under Section 41 of the Mental Health Act 1983 was also made to ensure that he continued to receive treatment in the long term and that the long term risk he poses to others is appropriately managed. This proviso ensured that he could not be released without

consideration by a Parole Board as it was deemed that although he was suffering from a mental illness a level of culpability of his actions was determined. The offender has lodged an appeal in relation to his sentence (result awaited).

9.2 The only parallel investigation in this case was the Coroner's Inquest and it is understood that the Coroner has accepted the findings of the criminal court.

## 10 Family/Friends Engagement

10.1 At the commencement of this review the family of the Woman was contacted and they were informed of the decision to undertake this review, its purpose and objectives. Upon the conclusion of the criminal proceedings, further contact was made and the Woman's son, daughter and ex-husband, were seen by the Domestic Homicide Review Chair and by a member of the Domestic Homicide Review panel. Subsequently two of the Woman's friends, a Vicar and a retired teacher who had known the Woman for over 40 years, her brother who is the offender's birth father, the offender's mother and the offender himself were also contacted, all of whom were willing to contribute to this Domestic Homicide Review and were seen by the Domestic Homicide Review chair and a member of the Domestic Homicide Review panel. The findings of this review were subsequently shared with the family who will be provided with a final printed copy of the review prior to publication.

10.2 The Woman was described as being *'larger than life with a massive personality, always cheerful with a good sense of humour and a loud laugh'*. She was a 'giver', had an attitude of 'can do' and hated any fuss made of her. She was at the heart of the local community, was a church warden, a governor at the local school, and was involved with the Brownies and Scouts. She was an avid gardener and had many friends. After her death a book of condolences was kept in the church and many members of the local community wrote about how she had made such a difference to their lives. Prior to her retirement she had been a Deputy Head Teacher at a local

school. The Woman was very close to the offender, supportive of him and often involved him in family gatherings. There was no indication that she was ever frightened of him or that he had ever previously been violent towards her. She attended many meetings at the schools he attended to support him and his mother and did all that she could to help him both emotionally and occasionally financially. After the offender left school she encouraged him in gaining employment and arranged for him to help with the church and with casual gardening work. She would be firm with the offender who respected her for that. Her relationship with the offender was described as *'unconditional love'.*

10.3 The family confirmed that the offender's behavioural problems were evident from an early age, he was always non communicative and had low self-esteem. Even at Infants school his mother described him as '*fidgety*' all of the time. The Woman's friend who had been a teacher at the junior school attended by the offender described him as a child who was slow at written work and would get frustrated if his work wasn't perfect. His reaction was to rip up his work and get angry with himself. His birth father had contact with him throughout his school life and attended some meetings with the offender's mother about him. The relationship between the offender and his birth father broke down after the incident when the offender threatened his stepmother with a knife. The offender's mother confirmed that she only gave him his medication whilst he was at school because she felt he did not need it at home where he was under no pressure, and she believed at that time that this was acceptable. However she now understands that it is better to continue with such medication rather than stop and start. It was believed by the family that the offender's mother tried to set boundaries but she was unable to instill good behaviour. Schools chose to contain his behaviour but he seemed to get away with things. The family felt that schools needed to take the welfare of other pupils and the teaching staff into consideration equally with the offender's welfare. It was felt by the Woman's daughter and ex-husband that teachers have difficulty in knowing how and where to access help for children

who present in the way that the offender did and that maybe more multi-agency teams and involvement is needed.

10.4 It was stated that the offender became unhappy and frustrated when he could not obtain an apprenticeship after successfully passing his college course. He had a job in a restaurant and then in a public house but after a disagreement with a manager he was moved to a different public house and was tasked with collecting glasses rather than serving behind the bar which he disliked and his mother described him as '*going downhill'*. After this he got involved in voluntary work and casual gardening.

10.5 The family stated that in the days before the death of the Woman, the behaviour of the offender had become more irrational and bizarre. He became convinced that he had been abused as a child and that everyone in the family knew about it. He seemed to be trying to understand what was wrong with him and had read some self-help books. He had asked the Woman about it and she had told him that it was not true and he was being ridiculous. He also discussed it with the Woman's son who encouraged him to seek help with his problems. The offender wanted to live with the Woman and her son and he was told that the Woman would have to discuss it with her son which she did. Her son said it was okay as a last resort but he would prefer him not to. The Woman and family were all relieved to hear that he had made a telephone call to seek help and had an appointment. The offender's mother in the week leading up to the death of the Woman stated that he had been asking her some bizarre questions and getting angry with her, calling her a bad mother. She was aware that he wanted to go and live with the Woman and her son and that he was a bit annoyed when she said she would have to speak with her son about it. The Woman and the offender's mother discussed the offender's increasingly irrational behaviour.

10.6 On 17 June 2016, the Domestic Homicide Review chair and a member of the Domestic Homicide Review panel saw the offender at the secure mental health hospital. Also present was a psychiatric nurse. He had previously received written information, via his psychiatrist, about the reason and

purpose of conducting a Domestic Homicide Review and this was reiterated to him by the Domestic Homicide Review chair. He stated that he understood and was willing to contribute to the Review. He responded well to a series of questions but did not elaborate in any depth. He said that at junior school he got bored, he annoyed people and his outbursts just happened even when on medication. He said he was *'forced'* to take his medication in the week but not at weekends when with his mom or dad. He said there was trouble at school. He was bored with learning but liked sport. He said at secondary school it was okay at first but then he just got bored. When asked why he got into trouble he said it was a bunch of things and he didn't like it at school. He liked it at the special school; he got his exams and was more controlled. There were less people and they knew how to deal with it if he got distracted. He stated that he took his medication when at the special school but was not sure whether it helped. He felt that after leaving school he got no support and '*just had to get on with it. Do things on my own'*. He said that he was okay at college and got his level 3 and the course was mostly practical. He had started to play rugby at age 12 and it helped to get his aggression out. He got into trouble on the pitch once and got 'took' to a disciplinary but he wasn't stopped from playing. After college he was unable to find work as an electrician because of the recession and did odd jobs and voluntary work. He spoke of the psychology treatment when he received CBT (Cognitive Behaviour Therapy) which he told them did not work nor did the medication but was told that was all that could be offered. He had 16 sessions which was all they could do and he still felt in the same state afterwards. He said that he didn't feel he could talk to anyone. He felt worse and went to see his GP who referred him to Solihull Healthy Minds. When he phoned Solihull Healthy Minds he thought the questions were scripted and it was hard to say how he felt on the phone. He wanted to see someone quickly. He said he thought he was taking his medication which was anti-depressants all of the time. He mentioned it was the Woman who had to explain things and to talk for him. When asked about his involvement with the police he just mentioned the incident with his step mother and denied that he had been drunk stating that he lost his temper after she had said '*not nice'* things about his family. He did

not make any further mention of the Woman or his family, apart from the fact that he got on well with his step-father and used to regularly see his birth father.

## 11. Analysis of Agency Involvement

11.1 From a very early age the behaviour of the offender had caused concern and there was considerable involvement of sectors within education and to a lesser degree, health concerning him. It is evident that the focus of interventions whilst he was in school was upon academic achievement and containing his behaviour rather than investigating the root cause. The risk of harm that he posed to others and to himself was never investigated or assessed in any depth at any time. Whilst at secondary school in a period of 2 years and 8 months there were at least 20 incidents of violent behaviour, but it is known that some data was lost due to a transfer of records electronically. Whilst at the special school, a period of 1 year 9 months, the offender managed to pass GSCE examinations but there were 10 incidents recorded whereby other pupils or teachers were assaulted by him. All of those incidents were dealt with within an education/health environment whereby the emphasis was upon containing rather than solving the problem. No other agencies were contacted, such as the police or youth offending teams which may have assisted, particularly in enforcing the seriousness of the offender's behaviour to himself and his family which could have resulted in an effective risk assessment. Whilst it is unclear whether any injury was caused to others it is apparent that offences of common assault and indeed of a threat to kill could have been considered and interventions made to protect others, to understand the root cause and potentially prevent future offending and the risk posed to others and to himself.

11.2 After leaving school and whilst at college the offender quickly came to the notice of the police which had been feared by his mother in view of his violent outbursts at school. His past behaviour was not known within the criminal justice sector and hence the disposals of his offences did not take into

account any of his past behaviour. Critically when he threatened his step mother with a knife, not only was his past caution for common assault not identified by another police service, but it appears that his ongoing violent behaviour was not taken into consideration when he then went on to commit further offences.

**KEY ISSUES**

- **Information Sharing/Multi Agency Working/Early Intervention**

11.3 It is evident from this Domestic Homicide Review that information sharing between education and health sectors concerning the behaviour of the offender took place but this did not extend any further to other agencies. It is recorded that during his infant junior, secondary and special school education he physically assaulted and threatened other pupils and teaching staff on numerous occasions. In addition much of the information gleaned by health practitioners regarding the offender's behaviour was given by the offender or his mother and the seriousness of his continuing and escalating behaviour seems not to have been fully understood and may have been minimised.

11.4 As an adult, the offender, aged 23 years, received psychological therapy, described by him as cognitive behaviour therapy. During these sessions he disclosed and described several incidents whereby he had assaulted others, including the assault upon his step-mother. Whilst there was discussion between the therapist and supervisors it was decided that that there were no immediate concerns to individuals or members of the public. Had a referral been made to a forensic psychologist, which was considered but decided against, then a different end of treatment assessment was a possibility and provision of an alternative exit plan could have been considered. The lack of a referral to the police was a missed opportunity bearing in mind that the offender had by this time come to the notice of the police on six occasions and the repeated pattern of his behaviour could have been taken into account when considering suitable treatment. Of concern is the fact that health practitioners have indicated that previous experience of contacting the police had met with a negative response. There are longstanding information sharing

protocols agreed between agencies in Solihull, which now includes a threshold agreement instigated by the Solihull Safeguarding Childrens Board. However during the relevant period of this Review there is evidence of poor communication and a lack of information sharing which prevented a holistic view being taken of all of the incidents of the repeated aggressive and harmful behaviour of the offender to others and indeed to himself.

11.5 Currently a generic Information Sharing Agreement (ISA) is being compiled, led by the police, between agencies within Solihull Borough with the purpose of clarifying and facilitating exchange of data. Therefore the following recommendation is made with a view to improving practice and clarifying the procedure to practitioners.

**RECOMMENDATION 2**

**Safer Solihull Partnership to oversee the implementation of the generic Information Sharing Agreement and to ensure that agencies accept responsibility to agree and ensure that staff are trained to fully understand the importance of when, why and how to make and respond to information exchange between agencies.**

11.6 Early intervention took place whilst the offender was at junior school with inputs from educational psychology. He was subject to a staged behaviour plan and was placed on school action plus of Special Educational Needs (SEN) code of practice. As a result regular review meetings were held and various methods of controlling his behaviour were attempted. In addition specialist interventions from Education Behaviour Disorder (EBD) team was requested and provided. There was also involvement of Child & Adolescent Mental Health Service (CAMHS) and these interventions continued when he transferred to secondary school with the exception of the Educational Psychological Service. Unfortunately due to a lack of records it is not known exactly what information was exchanged and upon what basis the secondary school took forward intervention work when the offender first started at the school. It is apparent that the school sought to manage his behaviour internally with the assistance of a placement at a Pupil Referral Unit (PRU)

and in-school support delivered through the Pupil Referral Unit, which proved unsuccessful and resulted in permanent exclusion. It is apparent that the interventions were insular to education departments with the focus being upon academic achievement. Despite a strong case the opportunity to move the offender to stage 4 prior to transfer from junior to secondary school and put a statement of special educational needs in place was missed. Had the offender been subject of a statement of special educational needs then it would have been apparent that the secondary school placement was not appropriate due to the needs of the offender. The provision of a special school placement would have been considered at that stage.

- **Mental Health Contact**

11.7 At the age of 11 years the offender received periodical support from mental health services. Initially this was from Child & Adolescent Mental Health Service (CAMHS) when he was diagnosed as suffering from Attention Deficit Hyperactivity Disorder (ADHD) and was prescribed a slow release of Ritalin medication. At first it appeared that the offender's behaviour had shown improvement and he seemed somewhat calmer but this did not last as his behaviour continued to give rise for concern. However the offender's early engagement with Child & Adolescent Mental Health Service was somewhat unproductive as he was extremely reluctant to attend the clinic and to engage with the psychiatrist which resulted in the psychiatrist feeling that no useful therapeutic work could be achieved with him. In addition inconsistent administering of Ritalin may have impacted upon the effectiveness of the benefits of the Ritalin medication, at that time. In 2005, when aged 14 years, the offender had further contact with Child & Adolescent Mental Health Service it was noted that he was clumsy and had symptoms that would fit with Oppositional Defiance Disorder (ODD). Further assessment by a psychiatrist resulted in the trigger for his angry outbursts being accredited to pressure at school and the focus was upon anger management and managing/containing his behaviour with the focus returning to his academic achievement. Upon his permanent exclusion from secondary school an assessment by the educational psychological service concluded that despite interventions the

offender's behaviour had escalated to a point where staff were unable to cope with his behaviour and that he was posing a risk to others. There was some further involvement with psychologists from the mental health service but it was felt that the offender engaged better with internal educational anger management support.

11.8 The offender and his mother continually sought help in respect of his mental health. He was seen on several occasions by his GP and from January 2010 presented with signs and symptoms of depression which was regularly reviewed and he was referred to the Community Mental Health Team. Diagnosed with mild depression he was prescribed anti-depressants which he was reluctant to take, unconvinced of the benefits and appears to have taken them intermittently. He stated a preference for psychological treatment which he received, during which he described his acts of violence towards others. As previously mentioned there was no referral to police, had there been a referral to the police this may have impacted upon his care. A referral for forensic psychiatric assessment was also discussed and decided against, as it was felt that the offender did not meet the criteria. Referrals for forensic assessments are usually in respect of service users who require hospital admission. Advice could however have been sought from forensic services for an expert opinion in respect of the offender and a referral considered if deemed appropriate. The review panel felt this was a missed opportunity for a more in-depth thorough assessment of the root cause and trigger points of the offender's behaviour. However it is not known whether a forensic referral would have changed the offender's treatment plan.

11.9 It is also apparent that the police when dealing with offences committed by the offender were focused upon the fact that he had often consumed alcohol or had taken cannabis. This may have masked any underlying mental health issues, particularly as they were unaware of his past behavior and medical history, which may have had an impact upon the disposal of offences and exchange of information with other agencies.

11.10 The offender's mother and the family described how the offender had become more irrational and bizarre in the days leading up to the death of the Woman. Two days prior to the Woman's death, the offender saw his GP reporting that he was in low mood with poor concentration and interrupted sleep. It was noted by the GP that he seemed to be asking *'for help'* and he was given details of Solihull Healthy Minds. This is a primary care service for low level intervention for adults suffering from common mental health problems including depression, anxiety and phobia issues. It is not a secondary care mental health service and is not a specialist psychology service. It is not known exactly how he presented when he saw the GP. He also discussed a physical condition for which he received a referral to hospital. The GP would have known that he had previously received secondary mental health services. The offender's self-referred to Solihull Healthy Minds, after assessment by them taking into account his past history, would not have been deemed appropriate, as his needs were greater than the service is commissioned to provide. It is apparent that the offender, his mother, the Woman and the family were all relieved that he was seeking help and had high hopes of what this service could deliver. In hindsight it seems that a referral back to secondary mental health would have been more appropriate. However, there would have been a delay before he could have been seen and would not in all probability have made a difference to the outcome of this case. Awareness of the limitations of such a referral need to be emphasised to General Medical Practitioners and the panel felt that further training in the Improving Access to Psychological Therapy (IAPT) and stepped care pathway to specialist psychology service was necessary which could be delivered as part of protected learning time sessions delivered to General Medical Practitioners.

**RECOMMENDATION 3**

**General Medical Practitioners to be reminded of the limitations of the service provided by Healthy Minds which is a primary health service and further training to be provided in respect of Improving Access to Psychological Therapy (IPT)**

- **Risk Assessment/Positive Action**

11.11 Throughout there was a lack of thorough risk assessment in relation to the offender and at no time was the full extent and history of his violent behaviour known to all of the agencies involved with him. Whilst he was subject to interventions, punishments and exclusions when in education, it appears that he was never made to understand the seriousness of the incidents. Matters were dealt within the education environment with only limited input from mental health. Offences were never reported to the police, children's social care or any other agency. Whilst it is understandable that professionals would be reluctant for a child to become subject of the criminal justice system, the offender may have viewed this lack of action as '*getting away'* with his behaviour and may also have minimised it to his family. Indeed this pattern continued when as an adult he came to the notice of the police, which had been feared by his mother. Despite committing six offences he only appeared at court on one occasion when he received a fine.

11.12 Had the offender's volatile and aggressive behaviour been known outside of the education and health sector when he was a child, he could have benefitted from intervention of the Youth Offending Service. This should have enabled an in-depth risk assessment with a view of preventing future harm to himself or others. Currently in Solihull there is a Youth Offending and Prevention Service formerly the Youth Inclusion Support and Intervention (YISP) service for young people between the ages of 8 and 17 years. This service is for children between those ages who:

- are already offending but have not been arrested or charged

Or

- are engaging in anti-social behaviour

and

- are known to one or more agencies

and

- are exposed to four or more of the following risk factors
    - living in a deprived household
    - inconsistent parental supervision
    - parents/carers failed to show care
    - difficulties with educational provision
    - not using leisure time constructively
    - associating with pro criminal peers
    - engaged in reckless activities
    - impulsive
    - easily bored
    - lacks understanding of the consequences of own actions

As can be seen the offender would have fitted into that criteria but unfortunately that scheme was not in place when he was in the relevant age group.

11.13 Also School Panels were set up in North Solihull in 2015 and in South Solihull in 2016. The aim is to ensure effective joint working between secondary schools, the police and key partners including Solihull Early Help Team, Solihull Youth Offending Service and Solihull Metropolitan Borough Council. The overarching objective of School Panels is to ensure consistent engagement that is proportionate to the needs of both schools and the police. Had such an arrangement been in place when the offender was in school then he would no doubt have been a subject of referral, discussion and risk assessment.

11.14 Currently it is also known that the Schools Behavior & Discipline Policy Guidelines have been reviewed and revised by Solihull Education Officers.

## 12 Good Practice

12.1 No evidence of good practice within agencies over and above that which was within normal service delivery has been found during this review.

12.2 However the relatively recent developments, certainly in respect of when the offender was in education and hence the opportunity of early intervention, provide the potential of current/future good practice. This relates to the Youth Offending and Prevention Service, School Panels, The Solihull Local Safeguarding Children Board - Threshold Guidance, and the review of the Schools Education Behaviour & Discipline Policy guidelines. It is therefore recommended that these developments be monitored, assessed and amended to ensure effective and improved multi-agency service delivery.

**RECOMMENDATION 4**

**Safer Solihull to seek assurance and evidence from agencies involved with the Youth Offending and Prevention Service, School Panels, The Local Safeguarding Board Threshold Guidance and Schools Behaviour and Discipline Policy, that these developments are regularly monitored, assessed and amended to ensure effective and improved multi agency service delivery.**

## 13 Lessons Learnt

a) Interventions made by the Education sector to address the violent behaviour of the offender were too insular with a lack of information sharing and multi-agency working.
b) The focus of interventions when in education were upon academic achievement and containing behaviour rather than investigating the root cause
c) There was a missed opportunity to escalate to stage 4 (Statement of Special Educational Needs) which resulted in an inappropriate secondary school placement
d) At no time was a holistic view taken of all of the incidents, past behaviour and the risk posed by him to others due to a lack of information sharing
e) There was a lack of in-depth risk assessment of the harm posed by the offender to others and to himself

f) Opportunity to share information gleaned by the mental health psychology service with police and forensic psychiatry service was missed
g) Disposals of offences committed by the offender failed to take into account past behaviour
h) Agency actions were insular rather than on a multi-agency basis.

The following recommendation is made in order to ensure that the lessons learnt from this Domestic Homicide Review, from previous Domestic Homicide Reviews in Solihull, together with regional and national findings are disseminated to all agencies, managers and practitioners in the Borough.

**RECOMMENDATION 5**

**Solihull Safer Partnership to ensure that the lessons learnt during this review and previous learning from Domestic Homicide Reviews locally, regionally and nationally be disseminated to all agencies, managers and practitioners by way of learning events to be held across the Borough.**

## 14 Conclusion

14.1 It was evident from an early age that due to his violent outbursts the offender posed a risk of harm to others and to himself. A critical incident occurred when he threatened his step mother but the serious nature of his actions were not fully understood nor investigated. Despite considerable contact with agencies he was never subject of a risk assessment and the root cause of his actions were never fully explored. Interventions to contain and manage his behaviour had very limited effect in relation to his behaviour.

14.2 He did however have a very mutually close and indeed loving relationship with his aunt, the Woman subject of this review. There is no evidence that he had ever been violent towards her or indeed towards her son. Whilst it could be predicted that he would eventually cause serious harm to himself or to another person it could not have been predicted that he would cause the death of the Woman and cause serious injury to her son.

14.3 The offender clearly was seeking help and had he had the benefit of close multi agency information exchange and forensic psychiatric assessment he may have received a diagnosis and treatment that could potentially have managed his condition and in turn may have resulted in a different outcome.

## 15 Single Agency Recommendations

15.1 The internal recommendations and action plan made by agencies to learn lessons and improve practice, and are as listed in Appendix B. These have been progressed during the course of this Review.

## 16. Overview Report Recommendations

**RECOMMENDATION 1**

**The Home Office issue guidance to schools (Academies, Free Schools or Independent Schools) not under the governance of a Local Authority in respect of participation and release of information for the purpose of Domestic Homicide Reviews.**

**RECOMMENDATION 2**

**Safer Solihull Partnership to oversee the implementation of the generic Information Sharing Agreement and to ensure that agencies accept responsibility to agree and ensure that staff are trained to fully understand the importance of when, why and how to make and respond to information exchange between agencies.**

**RECOMMENDATION 3**

**General Medical Practitioners to be reminded of the limitations of the service provided by Healthy Minds which is a primary health service and further training to be provided in respect of Improving Access to Psychological Therapy (IPT)**

**RECOMMENDATION 4**

**Safer Solihull to seek assurance and evidence from agencies involved with the Youth Offending and Prevention Service, School Panels, The Local Safeguarding Board Threshold Guidance and Schools Behaviour and Discipline Policy, that these developments are regularly monitored, assessed and amended to ensure effective and improved multi agency service delivery.**

**RECOMMENDATION 5**

**Solihull Safer Partnership to ensure that the lessons learnt during this review and previous learning from Domestic Homicide Reviews locally, regionally and nationally be disseminated to all agencies, managers and practitioners by way of learning events to be held across the Borough.**