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

Executive Summary

of the report into the death of a woman

who died in June 2015

Report produced by Gill Baker OBE, BA (Hons)

Independent Chair and Author

July 2017

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INTRODUCTION

This summary outlines the process and findings of this Domestic Homicide Review undertaken by the Safer Solihull Partnership domestic homicide review panel in reviewing the homicide of the woman who was resident in their area.

Pseudonyms have not used in this review as it was the preference of the family not to do so and to refer to the victim as the Woman and the perpetrator as the offender. This should serve to protect their identities and those of their family members.

The Woman, of white British ethnicity, was aged 67 years at the time of her death and she was the paternal aunt of the offender, also of white British ethnicity, who was aged 24 years at the time.

Purpose

The purpose of a Domestic Homicide Review (DHR) is to:

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

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

- 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

A Domestic Homicide Review is not an inquiry into how a victim dies or into who is culpable as those matters are for Coroners and criminal courts to determine. Domestic Homicide Reviews are not specifically part of any disciplinary enquiry or process. Where information emerges during the course of a Domestic Homicide

Review which indicates that disciplinary action should be initiated then the relevant agency disciplinary procedures should be undertaken separately to the Domestic Homicide Review process.

In production of the Domestic Homicide Review report agencies have collated sensitive and personal information under conditions of strict confidentiality. The Safer Solihull Partnership has balanced the need to maintain the privacy of the family with the need for agencies to learn lessons relating to practice identified by the case and has authorised the publication of sufficient information to enable this to take place.

A decision to undertake a Domestic Homicide Review was made on the 25 July 2015. Agencies were required to secure their files in order to compile an Individual Management Review (IMR) to provide an independent, open and critical analysis of individual and organisational practice. The Individual Management Reviews identify lessons learnt by the individual agencies, highlight any good practice and include recommendations for single agencies to improve practice.

CONTRIBUTORS TO THE REVIEW

Independent Management Reviews

- 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

Information Reports

- Connexions
- Talent Match (Birmingham Voluntary Service Council)

- Solihull Healthy Minds
- Solihull MIND
- West Midlands Ambulance Service NHS Foundation Trust
- Warwickshire Police

All agencies who contributed to the Review confirmed to the Safer Solihull Partnership that their authors were independent of this case.

DOMESTIC HOMICIDE REVIEW PANEL

Independent Overview Chair and Author: Gill Baker O.B.E.

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 from West Midlands Police she has been an independent chair and/or author of several serious case reviews, domestic homicide reviews and Multi Agency Public Protection Arrangements (MAPPA) reviews.

Panel Members

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. The Panel met on nine occasions and the members are:

- 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

TERMS OF REFERENCE

- *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?*

SYNOPSIS

In June 2015 police officers 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.

In 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 grevious 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. 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.

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 GCSE 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.

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

FAMILY AND ASSOCIATES ENGAGEMENT

During this review the family of the Woman, which included the parents of the offender, the offender himself and two close friends of the Woman were contacted, were willing to contribute to this Review and were subsequently seen by the Domestic Homicide Review chair/author and a member of the Domestic Homicide Review panel. Their comments have been included in the overview report and the findings have been shared with the Woman's family and the offender's mother. Overwhelmingly it was evident that there was a close and loving relationship between the Woman and the offender. She was always supportive of him and he sought help and guidance from her.

LEARNING

Key Issues:

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

- **Mental Health Contact**
- **Risk Assessment/Positive Action**

Lessons Learnt

- 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.
- The focus of interventions when in education were upon academic achievement and containing behaviour rather than investigating the root cause
- There was a missed opportunity to escalate to stage 4 (statement of special educational needs) which resulted in an inappropriate secondary school placement
- At no time was a holistic view taken of all of the incidents, past behaviour and the risk posed by him to others and himself due to a lack of information sharing
- There was a lack of in-depth risk assessment of the harm posed by the offender to others and to himself
- Opportunity to share information gleaned by the mental health psychology service with police and forensic psychiatry service was missed
- Disposals of offences committed by the offender failed to take into account past behaviour
- Agency actions were insular rather than on a multi-agency basis.

GOOD PRACTICE

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

However 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 new Youth Offending and Prevention service, School Panels, The Solihull Local Safeguarding Children Board Threshold Guidance, and the review of Schools Behaviour & Discipline Policy guidelines.

CONCLUSION

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.

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.

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

DHR OVERVIEW 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.

SINGLE AGENCY RECOMMENDATIONS

Birmingham & Solihull Mental Health Foundation Trust (BSMHFT)

1. Working in partnership: BSMHFT Community Health Team and Psychology Service (Solihull) should review how they work in partnership both within the trust and with external partners.

2. Practice: BSMHFT Community Health Team and Psychology Service (Solihull) should review how they work to ensure that multidisciplinary scrutiny is applied to cases where there is a sole practitioner responsible for the provision of care.

3. Resources: Commissioners should consider whether a forensic service for patients residing in the community and not requiring hospital admission is required.

Heart of England Foundation Trust

1. ED (Emergency Department) leadership team to review the documentation requirements for assessment of punch type injuries to hands.

2. Discuss the findings of this review (The Trust Independent Management Review IMR) with the current provider team for Child & Adolescent Mental Health Service to consider whether any further actions are required for young people presenting with Attention Deficit Hyperactivity Disorder and angry outbursts.

Solihull Education

1. (a) Clear management oversight of the work of the Special Educational Needs (SEND) service (including Education Psychology (EP), Education Behaviour Disorder (EBD), School Improvement Support Service (SISS), statementing team) so that cases do not drift, roles are clear and professional boundaries are not blurred

(b) There should be clear multi-disciplinary meetings, to give an honest and accurate appraisal of their work and its impact. Multi-disciplinary agency

meetings should be where accountability of departments to the plan takes place, and impact is measured, with any drift and delay being addressed.

(c) Ensure that there are clear transition arrangements in place for all pupils receiving Special Educational Needs (SEN) support where there are multi-disciplinary meetings, attended by both the receiving school and the feeding school; so that they move to the correct school and receive appropriate on-going intervention.

2. Introduce a professional dispute resolution process and a clear escalation process, where schools and other partners can independently raise concerns, including the cancellation of important multi-disciplinary meetings.

3. Ensure that there are clear transition arrangements in place for all pupils receiving Special Educational Needs support where there are multi-disciplinary meetings, attended by both the receiving school and the feeding school; so that they move to the correct school and receive appropriate on-going intervention.

4. Recognising disguised compliance of parents/carers, and taking appropriate action, to avoid drift and delay.

5. Reminding education providers of the need to deal with violent incidents appropriately, including risk assessments, stress management, employee assistance programme, the use of the exclusions policy and the engagement of the police and youth inclusion support service. Violence cannot and should not be tolerated.