Safer Sandwell Partnership

Domestic Homicide Review

Overview Report

Jeera and Amrinder
(who died in early 2020)

Author: Simon Hill

Please note that this document contains descriptions of violence which people may find distressing.

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FOREWORD

The Safer Sandwell Partnership (SSP), the Independent Domestic Homicide Review (DHR) Chair, panel members and participating agencies join in expressing our sincere condolences to the families, friends and colleagues of Jeera and Amrinder for their loss.

1.1 Timescales for the Review

1. In early 2020 notification was sent by the West Midlands Police Public Protection Unit to the Domestic Abuse Incident Coordinator within Sandwell's Domestic Abuse Team, advising that the circumstances of this case may fit the definition of a Domestic Homicide Review as defined in the Domestic Violence, Crimes and Victims Act 2004.
2. Following notification of this incident, the Domestic Abuse Team collated a range of information from partners to establish the contact they had had with the victims, the perpetrator and family members. Agencies that had been involved with the victims, perpetrator and family members were advised to secure their records.
3. The information from partner agencies was shared with the DHR Standing Panel and Chair of the Safer Sandwell Partnership who, on 16.03.2020, decided that the criteria for holding a Domestic Homicide Review under Section 9 (3) of the Domestic Violence, Crime and Victims Act (2004) was clearly met and directed that such a review be carried out into the circumstances surrounding this case. The Chair of the Safer Sandwell Partnership Board confirmed this on 16.03.2020.
4. The legislation requires that **'a review of the 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 he/she was related or with whom he/she was or had been in an intimate personal relationship'** should be held, with a view to identifying the lessons to be learnt from the death.
5. The purpose of a Domestic Homicide Review is set out in section 2.7 of the statutory guidance issued by the Home Office to support the legislation (i.e. the Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews – December 2016). Primarily the purpose of a DHR is to 'establish what lessons are to be learnt from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims'.

1.2 Confidentiality

1. The Safer Sandwell Partnership maintained confidentiality throughout this process. Information was only shared with participating agencies. Those agencies were required to ensure that information received was restricted to the IMR author, any staff members with whom it would be necessary to share information with to ensure the effectiveness of the review process and senior leadership teams responsible for signing off their agency IMRs.
2. Home Office Guidance advises that confidentiality of family members' identities should be assured by anonymisation. The pseudonyms used in the report were chosen by Deepika.

The victims were:

Jeera was 52 at the time of the homicides and was mother to the perpetrator and to Deepika was of Asian ethnicity and a follower of Sikhism.

Amrinder was 54 at the time of the homicides, was stepfather to Deepika and Gurnam and was of Asian ethnicity and a follower of Sikhism.

3. The perpetrator was:

Gurnam who was 25 at the time of the homicides, was of Asian ethnicity, and was a follower of Sikhism.

4. Family members

Deepika was the daughter of Jeera and Jaswinder, and sibling of Gurnam and was 22 at the time of the homicide.

Jaswinder was Jeera's ex-husband and Gurnam and Deepika's father.

1.3 Methodology

1. The Safer Sandwell Partnership conducted an initial scoping of agencies to identify the level of contact they had had with the family. Thereafter agencies were asked to complete a chronology of that involvement.
2. Agencies were subsequently asked to undertake Individual Management Reviews (IMRs). The Chair conducted a briefing of IMR authors to discuss the key lines of enquiry and Terms of Reference of the Review.
3. The DHR panel members were independent of the events described in this DHR. The panel met on:
    - 04/06/20
    - 16/09/20

- 26/11/20
- 11/03/21
- 04/05/21

4. The Overview Report was accepted by the Responsible Authority on the 21/10/21 and was shared with Deepika before submission to the Home Office.

1.4 Involvement of Family & Friends

1. The DHR was commenced immediately before the COVID-19 pandemic and therefore any family contacts were via email and Microsoft Teams meetings. The review contacted the surviving immediate family members; Deepika and Amrinder's son. They both received a letter from the Chair, the Advocacy After Fatal Domestic Abuse (AAFDA) leaflet and Home Office leaflet explaining the DHR process. Gurnam was also informed of the review and, via discussions with his probation officer, invited to participate. Gurnam met with his probation officer in September 2020 and was given the Home Office Domestic Homicide Review information leaflet explaining the review process, however Gurnam declined to talk about the review. Amrinder's son did not choose to be involved with the DHR.
2. Deepika was encouraged to participate at the point she felt able and via whichever medium she preferred. She asked to share with the DHR panel any concerns or questions she felt were relevant and was sent the Terms of Reference as well as the Home Office guidance notes.
3. Deepika was offered the opportunity to present her perception and insights relating to the case, directly to the DHR Panel. She was supported by a Victim Support Homicide Case Worker and from 100 Families[1] and both were present during her conversation with the chair and panel in November 2020, as was her boyfriend. The Panel were humbled by her thoughtful and compassionate observations about her family's experiences as they sought support from agencies.
4. The Safer Sandwell Partnership and Chair ensured that Deepika was updated throughout the DHR, including in relation to emerging key learning. Deepika chose to email the Chair with reflections and observations which the DHR panel appreciated.

1.5 Contributors to the Review

- Clinical Commissioning Group (Sandwell & West Birmingham & Northamptonshire) - now the NHS Black Country Integrated Care Board (BC ICB)

[1] **100 Families provide support and advocacy for families after the killing of a person by someone with mental illness. They educate professionals and seek to embed learning**

- Black Country Healthcare NHS Foundation Trust (BCHFT) - formerly Black Country Partnership NHS Foundation Trust
- Sandwell & West Birmingham Hospitals NHS Trust
- The Dudley Group NHS Foundation Trust
- CAMHS Northants
- Sandwell MBC Education
- Birmingham CC Education
- Sandwell Children's Trust (including Sandwell Youth Offending Service)
- National Probation Service (Black Country cluster)
- West Midlands Police
- Children First Northamptonshire (CFN)

(Chair's Note: The DHR approached the Child and Family Court Advisory & Support Service CAFCASS to request they contributed to the Review; however, no response was received.) The request for CAFCASS submissions required an application through Sandwell MBC Legal Services and significant delays in this process, and in retrieving files, led to the DHR seeking disclosure of CAFCASS reports directly from the family. Having reviewed the available information, it was felt by the Chair that no further purpose would be served pursuing disclosure of CAFCASS files.

1.6 The Review Panel

Organisation	Role
N/A	Independent Chair and Overview Author (Simon Hill)
Sandwell & West Birmingham Clinical Commissioning Group - Now NHS Black Country ICB	Designated Nurse for Safeguarding Adults
Sandwell & West Birmingham Hospital NHS Trust	Named Nurse for Safeguarding Children
Black Country Healthcare Foundation NHS Trust[2]	Interim Safeguarding Consultant
National Probation Service	Deputy Head of Probation - Black Country
Black Country Women's Aid	Chief Executive Officer

[2] **Formerly Black Country Partnership NHS Foundation Trust**

Sandwell Children's Trust	Service Manager – Quality Assurance and Safeguarding Unit
Youth Offending Services Sandwell Children's Trust	Deputy Service Manager - Youth Offending Team
Education, Sandwell MBC	MASH Education Officer - Attendance & Prosecution
Neighbourhoods, Sandwell MBC	Lead Community Safety Co-ordinator
West Midlands Police	Detective Inspector, Public Protection Unit
Sandwell MBC	Domestic Abuse Team Manager
Sandwell MBC	Domestic Abuse Incidents Review Coordinator
Sandwell MBC	Core Business Support Officer

1.7 The Independent Chair

1. The DHR Chair / Overview author, Simon Hill, is a retired West Midlands Police officer since 2013, who served on the Public Protection Unit, investigating both child and adult protection cases. For 5 years he was responsible for the Review Team contributing IMRs to SARs, Safeguarding Child Reviews and Domestic Homicide Reviews.
2. He has conducted numerous DHRs and SARs around the West Midlands region in the last seven years. He regularly presents learning from SARs and DHRs at events held by Safeguarding Partnerships as well as facilitating multi-disciplinary workshops. For the last four years he has provided Level III Adult and Child Safeguarding training for Clinical Commissioning Groups (CCGs) and Hospital and Mental Health Trusts.
3. He was not involved with any of the events which are the subject of the review and was no longer serving as a police officer during the timeframe under review.

1.8 Parallel Processes

1. Gurnam was sentenced to life imprisonment with a minimum of 36 years for murder in the summer of 2020, therefore the Coroner adjourned the inquests not to be resumed and no conclusion was reached by the Coroner.

2. NHS England did not carry out a Mental Health Homicide Review in this case because the criteria for such reviews had not been met. Gurnam was not receiving mental health support at the time of the homicide.

1.9 Equality & Diversity

1. In conversation with the Chair, Deepika, the victim's daughter, recognised that her mother's loyalty to and patience with her son was grounded, in part, in cultural attitudes that related to the perceived gender roles and expectations.

2. Deepika was clear that her mother did not feel unable to access services, as a survivor of domestic abuse she had accessed refuge provision both in Northampton and the West Midlands. She called Police when she could not control Gurnam and sought support from Child and Adolescent Mental Health Services (CAMHS) and where necessary Children's Services.

3. Jeera was a deeply religious woman and only shared the full extent and nature of her problems relating to Gurnam with elders at the Gurdwara[3]. Deepika described the significance of the community support the family were offered over the years by the Gurdwara.

4. As Gurnam moved from childhood into adolescence and adulthood, Jeera, who was a proud and private woman, became increasingly unable to share her experience with friends in her community, although her sister in India offered moral support and practical support where it was feasible.

1.10 Dissemination

In addition to the organisations contributing to this review (listed in paragraph 1.6), the following will receive copies of the learning from this report:

- Sandwell Children's Safeguarding Partnership
- Sandwell Health and Wellbeing Board
- Sandwell Safeguarding Adults Board
- West Midlands Police and Crime Commissioner
- Children First Northamptonshire (CFN)
- University Hospitals Birmingham NHS Foundation Trust
- Northampton Police

[3] The Gurdwara is a place of assembly and worship for followers of the Sikh religion. There are no priests, and men or women can lead prayers if they are able, although Gurdwaras generally have a Granthi, who organises prayers and reads from the Sikh holy book. Extending hospitality to all faiths in the Gurdwara and feeding anyone who needs help who comes to the Gurdwara is central to the faith.

2 The Terms of Reference for the Review

1. All agencies were asked to review their involvement with the family during the period between 2002 when the family moved to Sandwell until Jeera and Amrinder's death in early 2020.

2. Initial scoping suggests that from around 2004 to 2012, child to parent[4] abuse (CPA) also called child and adolescent to parent violence and abuse (CAPVA), played a significant part in the family history. It appears that the victim, Jeera, and the perpetrator's younger sibling, Deepika, as well as the perpetrator's father, Jaswinder, were all possibly victims of what would be recognised now as a form of domestic abuse at the hands of Gurnam.

3. The Chair and panel recognise that understanding of CPA has developed significantly since the events captured in the initial scoping.

4. The DHR will seek to identify the pathways to support for families experiencing CPA that currently exist and identify relevant learning for service providers in 2021. We will consider how effectively agencies manage both child and adult safeguarding in the context of CPA.

5. There is a distinction to be drawn between child/adolescent violence and abuse in part because, since 2013, 16 and 17-year-olds can be either victims or perpetrators of domestic abuse under the Home Office definition of domestic abuse and adolescent to parent abuse was recognised as a domestic abuse issue.

6. Child/adolescent parental abuse clearly can continue after the abuser is eighteen. In this case, the perpetrator turned 18 years of age in 2012. Engagements and incidents thereafter, whilst no longer CPA, should be considered to identify if safeguarding responses to the risk of domestic abuse were appropriate and informed by the known antecedent history, which included domestic abuse-related cautions and convictions whilst an adolescent and a young adult.

All individual management reviews should address the following specific issues identified in this particular case:

1. What knowledge or information did your agency have that indicated Jeera and Amrinder might be at risk of abuse and Gurnam a perpetrator of domestic abuse?

    - How did your agency respond to this information to protect them?
    - Was this information shared?

[4] There is no definition of CPA but this definition is helpful from Holt A. (2015) Working with adolescent violence and abuse towards parents: *"a pattern of behaviour, instigated by a child or young person, which involves using verbal, financial, physical and/or emotional means to practice power and exert control over a parent…The power that is practiced is, to some extent, intentional, and the control that is exerted over a parent is achieved through fear, such that a parent unhealthily adapts his/her own behaviour to accommodate the child."*

- If so, with which agencies or professionals?

2. Did your agency have policies and procedures for Domestic Abuse, Stalking and Harassment (DASH) risk assessment and risk management for domestic violence and abuse victims or perpetrators (including updated assessment tools)?

    - Were those assessments used correctly in this case?
    - Does your agency have identified pathways to support perpetrators, as well as victims of domestic abuse?

3. Should your agency be using 'routine enquiry' in line with current NICE guidance (or enquiry where health indicators that could indicate domestic abuse are present), to establish if a client is a victim of domestic abuse? Did any opportunities arise in your agency's engagements with the victims that meant they should have been asked such questions? Were such conversations recorded in client notes?

4. In assessing your agency's responses to domestic abuse risk in this case, what difference did it make (if any) that the case involved a son posing a risk to parents and a step-parent, rather than an intimate or former intimate partner?

5. Were professionals sensitive to the ethnic, cultural, linguistic and religious identities of the victims, the perpetrator and their families? Was consideration for vulnerability and disability necessary? Were any of the other protected characteristics relevant in this case?

6. To what extent in your agency's involvement with the family is there evidence that professionals adopted a holistic approach to identify domestic abuse risk and any child or adult safeguarding issues? How did your agency assess whether Jeera and Amrinder were able to articulate what was happening in their life (on those occasions when either party accessed services)?

7. Identify any occasion where your agency was approached by either of the victims, or other family members, seeking either to:

    - share information concerning risk from the perpetrator,
    - or to obtain support for the perpetrator.

    Were responses appropriate?

    What, if anything, prevented your agency sharing information or taking action?

    Were they signposted to other agencies or organisations?

8. There is evidence from scoping that at various points from adolescence into adulthood, the perpetrator was using alcohol and cocaine. (Sandwell DHR 9 acknowledged the risk from cocaethylene; including psychosis.)

   Jeera and Deepika are believed to have shared their concerns about the signs of psychosis exhibited by the perpetrator and his use of alcohol and drugs.

   - Was your agency aware of these co-morbidities, and what support and safeguarding advice was given to the perpetrator or family?
   - Could the response have been improved?

9. Identify any lessons learnt and implemented during the review process.

   - Are there lessons to be learnt from this case relating to the way in which this agency works to safeguard victims and promote their welfare, or the way it identifies, assesses and manages the risks posed by perpetrators?
   - Where could practice be improved?
   - Are there implications for ways of working, training, management and supervision, working in partnership with other agencies and resources?

10. How has your agency implemented the West Midlands Domestic Violence Standards (link)?

The following agencies should, in addition, answer questions 11 to 16 below that relate to what appears to be an emerging theme of this DHR, child to parent violence and abuse:

- CCG (Sandwell & West Birmingham & Northamptonshire)
- Black Country Healthcare NHS Foundation Trust - formerly Black Country Partnership NHS Foundation Trust
- CAMHS Northants
- Sandwell MBC Education
- Birmingham CC Education
- Sandwell Children's Trust (including Sandwell Youth Offending Service)
- National Probation Service (Black Country cluster)
- West Midlands Police
- Children First Northamptonshire (CFN)

11. Identify whether CPA was recognised by your agency in policy, procedures, data recording or operational practice during engagements with the perpetrator or members of the family and describe the impact this had.

12. Regardless of whether CPA was formally identified, consider any indications of professionals assigning responsibility for the behaviours to the child or the parents, rather than considering they were vulnerable individuals in their own right. Did professionals identify what they believed were causes or factors impacting upon the child's behaviours and, if so, were these recorded and acted upon?

13. Although CPA may not have been recognised, how effectively did agencies work together to support Gurnam and his family? What were the challenges encountered and how were they addressed?

14. Did agencies recognise that Deepika was a victim/at risk of abuse from her sibling? Were any child safeguarding procedures followed in relation to Deepika?

15. Describe whether your agency now has clear policy and procedure or guidance relating to CPA and in what ways (if any) would your agency expect colleagues to respond differently to the same CPA concerns, were they reported today?

16. What learning can you identify for your agency from your review of this case, in relation to CPA?

Question 17 is to be answered by:

CCG (Sandwell & West Birmingham & Northamptonshire)

Black Country Healthcare NHS Foundation Trust - formerly Black Country Partnership NHS Foundation Trust

- Sandwell & West Birmingham Hospitals NHS Trust

17. In identifying health provision and pathways to support that may have been offered or provided to Gurnam, consider any:

- Evidence of health inequalities in what was available
- Service provision addressing the inequalities

that are known to be experienced by ethnic minority groups in Sandwell.

Question 18 is for Sandwell Children's Trust

18. In 2013, the National Probation Service apparently attempted to access antecedent child protection information in relation to Gurnam, a former Looked After Child, who had been convicted of a domestic

abuse-related offence. The information was not shared, apparently because Gurnam was no longer a child.

- Was a refusal to share information in line with policy in these circumstances? (Does this remain the case in 2020?)
- How could an agency working with an adult find out from Sandwell Children's Trust about relevant child protection history that may have a bearing upon adult safeguarding?

Question 19 is for Children First Northamptonshire (CFN)

19. Gurnam had been a Looked After Child in Sandwell from March 2010 to August 2010 and had spent some months in residential care.

    - To what extent was the support offered by CFN to Gurnam under a CIN plan, informed by a clear understanding of the period Gurnam spent as a Looked After Child?
    - Identify what CFN would consider to be 'best practice' were the same concerns and history encountered in a child protection case in 2020.

3 Background and Information

1. Jeera married Jaswinder in 1993 and moved to the UK. They had two children, Gurnam and Deepika. (Jaswinder had been married before, but that marriage ended when his first wife left, alleging abuse.)
2. Jeera apparently missed India and her sisters, who she had not seen in years. Her first language was Punjabi, and her command of English was described by her daughter as '*not great*'. Deepika explained that her mother had a 'British' accent that meant that, although she would require an interpreter to understand more complex areas of discussion, professionals may have not appreciated this to be the case.
3. The family lived initially in Northamptonshire. Jeera apparently experienced a significant amount of domestic abuse. This included a great deal of physical abuse at the hands of her husband which was often witnessed by Gurnam and Deepika. Jeera had described how Jaswinder regularly threatened to kill her (Jeera) if she ever tried to leave him. Living as the family did with the extended family, Jeera experienced bullying by her mother-in-law and sister-in-law towards whom she was expected to be subservient. They allegedly were complicit and encouraged the domestic abuse by Jaswinder.
4. Jeera escaped from Jaswinder in August 2002 and moved with her children first to relatives and then to a refuge in the West Midlands. Gurnam was 8 and Deepika was 5 years old. Jeera was then involved in a protracted and acrimonious custody battle with Jaswinder during 2003 and 2004. Probably because of

her isolation and language difficulties, Jeera never reported the Northampton domestic abuse incidents to Police. This enabled Jaswinder to deny all allegations made against him or his family during the custody dispute.

5. The children's guardian reports and a subsequent psychiatric assessment of the children in February 2004 recognised their presentation was consistent with having lived with and experienced the impact of being both victims of, and witnessing, domestic abuse upon Jeera. Ultimately the court gave full custody to Jeera and Jaswinder was given no access to Gurnam and Deepika. Deepika considered this a significant point at which the harm done to the emotional wellbeing of Jeera and the family was intensified, due to the nature of the custody process.

6. Jeera raised her children in Sandwell on her own and, after living in several other addresses, moved to home address 1 with the children. It remained a property she owned until the homicide.

7. Jeera apparently met Amrinder in 2017, at their Gurdwara. Born in Kenya, Amrinder had worked as a dental technician for 10 to 15 years. He had a great love of all things automotive (he had previously worked in a garage). He enjoyed watching rallying and motorsport.

8. Amrinder had been married and had a son, but that relationship ended in 2014. He was estranged from his son and there was a degree of family tension when he started a new relationship with Jeera, caused in part by the fact that Amrinder's elderly mother lived at home address 2 until she died in December 2019. Jeera had previously had a full-time job but, when she married Amrinder, she reduced her hours to help with the care of his mother.

9. Jeera and Amrinder shared their faith and, according to Deepika, were 'soulmates' and extremely well suited to each other. They attended the Nagar Kirtan together (a processional singing of hymns through a community) in 2019.

10. Deepika considered Amrinder to be a father figure; the only person she considered had filled that role in her life. He discussed with Deepika coping strategies and how to support her mother with Gurnam, on many occasions. Amrinder went into the relationship and marriage with 'eyes wide open'; Jeera explained to him the historic problems with Gurnam, and he undertook to offer support to the entire family. In 2018, Jeera and Amrinder married and moved into home address 2, Amrinder's home. Gurnam remained in home address 1. In late 2019, Jeera and Amrinder encouraged Gurnam to move home to address 2.

11. The couple could see that Gurnam needed close support and they felt that would be best achieved by a shared home. Gurnam was due to move into address 2 permanently but, in early 2020, spent what was

probably his first overnight stay. There is no evidence of what caused the incident, but Gurnam attacked and murdered his mother and stepfather, stabbing them both repeatedly. Deepika raised the alarm after she had been unable to raise them, and Police forced entry and found them deceased. Gurnam was arrested and charged with murder. He was convicted in summer 2020 and sentenced to 36 years' imprisonment. Gurnam had not claimed diminished responsibility in his defence and at court claimed he acted in self-defence which the jury did not accept.

4 Chronology

Author's note: The Chronology will indicate in relation to some incidents and, where relevant, the children's ages. Gurnam's age is shown in brackets after the month/date the incident was recorded. In relation to Deepika's age, this will be shown in brackets after her name.

4.1 Introduction to the Chronology

1. The chronology will be detailed to describe the perpetrator's (Gurnam) evolving behaviours and presentation to both family and professionals, as he grew up and moved from childhood into adolescence and then adulthood. The victim Jeera and her daughter Deepika, and later Amrinder, attempted to support Gurnam and respond appropriately. The DHR will seek to describe the impact of trauma on the entire family and identify the balance between the need for child and adult safeguarding in their broadest sense, as well as identifying the risk to the entire family as Gurnam's child to parent abuse (CPA) intensified. Gurnam remained a threat to his family into adult life, but this was not identified as domestic abuse.
2. The DHR is conscious that Amrinder played a peripheral role in this chronology. This is in no way intended to diminish the importance of the tragedy that befell him. The DHR is clear that he provided support to Jeera and Deepika and was loved by them both. However, his opportunities to impact on this narrative were limited.

4.2 The first period of CAMHS involvement with the family: October 2003 to August 2005

1. Gurnam was first referred to Child and Adolescent Mental Health Services (CAMHS) in mid-October 2003 by staff at his first primary school in the West Midlands. He was already at risk of exclusion due to '*extreme behaviour issues'.* They described Gurnam as finding it '*nearly impossible to keep his hands and feet to himself and children are becoming afraid of him because of his aggressive tendencies'*. The referral letter provided vivid descriptions of Gurnam's concerning behaviour; physically aggressive behaviour towards

female staff and his mother, typical behaviour patterns of anger, inappropriate talk and interest in death, hurting people or animals and playing games mimicking shooting and fighting.

2. Gurnam and his mother Jeera did not engage with CAMHS for a first assessment until March 2005. The BCPFT IMR details how the concerns took so long to address. The initial appointment letter (sent within the Trust target timescales) was sent to the refuge, arriving after the family had left, and led to Gurnam 'falling off' the waiting list. When the school chased the referral in June 2004, a new series of appointments were set for late September. Apparently, an unidentified family member cancelled the sessions saying the service 'w*as not required*'. CAMHS acknowledged that none of the referrers were informed, which was unfortunate, because the causes for concern evidenced in the referral were still witnessed by professionals in contact with Gurnam.

3. Gurnam started at a new primary school, where the same worrying behaviours were quickly recognised and the Special Needs Education Co-ordinator (SENCO) wrote to CAMHS for an update, describing again the concerning threats and assaults to Jeera. She noted also that Gurnam was obsessed with violence against his father saying that he talked about joining the army and '*dropping a bomb on him'*. The school pushed for the appointments to be expedited because of growing concerns. This was the first example of a persistent element of Gurnam's presentations; threats against his father. The letter identified the traumatic impact of the domestic violence Gurnam had witnessed in his early childhood.

4. In March 2005 (10), Gurnam and Jeera attended for a first assessment at CAMHS; 18 months after the initial referral. There was no suggestion during this lengthy wait for assessment that Gurnam had improved, in fact it seems likely he had deteriorated. It was noted in the BCPFT IMR that despite a request for a Punjabi interpreter, none was present. This appeared to be a consistent weakness of practice during the CAMHS engagement with the family and may have contributed to undermining Jeera's ability to express fully her concerns. No evidence of psychosis was observed. The assessor noted Gurnam was still sleeping in his mother's bed. In answer to the question: the problem '*is having a mild/moderate/considerable impact on the family's life and functioning',* the assessor ticked '*moderate*'. The first assessment therefore identified the level of support needed as individual therapy to address anger and possible post-traumatic stress.

5. The Interim Safeguarding Consultant for the BCHFT observed at panel that it would have been appropriate at this early stage to refer Gurnam to a consultant paediatrician who could have reviewed the part played by trauma, anxiety and potentially ADHD as triggers to Gurnam's presentations.

6. A feature of Jeera's encounters with CAMHS was that very often she described an improvement in Gurnam's behaviour or that some behaviours had '*stopped*'. Although this could have been accurate, the

pressures upon a family revealing violence in the context of Child to Parent Abuse (CPA) will be discussed at length in the analysis. It is possible Jeera felt the need to downplay the impact that these behaviours, that had lasted at least two years, were having on her and Gurnam's sibling. The surrounding evidence available suggests Gurnam's behaviour was already having a considerable impact on the whole family.

7. There is no evidence of any consideration or recognition in the mental health assessments of the gradual disparity in physical strength between parent and child. As Gurnam grew up, the level of risk of physical injury to his mother and sister increased significantly. Although there was a record of the risk of violence against Jeera and Deepika, there was no recorded consideration of a child protection referral relating to the risk to Deepika. (In August 2005, Deepika (8) was in the waiting area during a CAMHS appointment, but there was no attempt to speak to her, or hear her voice and understand the impact her brother's violence and threats were having on her life.)

8. The notes of the 2005 sessions identify Gurnam's concerning attitudes and behaviours but also focus significantly on Jeera's parenting and boundary settings. It appeared to be the case that the CAMHS Psychologist spent at least as much time talking with Jeera alone as was spent working with Gurnam to recognise the cause of his behaviours. The analysis will consider what potential impact adverse childhood experiences (ACEs) have on children, based upon our understanding in 2021.

9. Gurnam was seen twice by the same CAMHS professional, Psychologist 1, once in June (11) and then in August 2005 (11). At the third session in late August, Jeera came alone. It appears the psychologist could speak Punjabi, but also recorded the difficulty in explaining the subtlety in Gurnam's behaviours in Punjabi.

10. It is clear from the available notes that Psychologist 1 identified problems in Jeera's parenting responses as a contributory cause of Gurnam's behaviours. He noted; '*if he can't have his way, he attacks his mother, swears at her and attempts to strangle her. <u>Mum gives in.</u>*' The underlining for emphasis suggests that Jeera may have felt blamed for her reaction, rather than Gurnam held to account for his behaviours.

11. Psychologist 1 identified that in Jeera's first marriage, when she began to be experiencing DV, she had slept separately from her husband and the children had regularly slept with her for comfort. This habit continued, but the Psychologist concluded Jeera thinks '*erroneously'* that it is OK for Deepika (8) but not Gurnam. He was not '*barred'* completely but the Psychologist identified that the decision caused jealousy and aggression towards Deepika.

12. The Psychologist's plan appeared to imply that Jeera was at fault. '*Essentially mum needs to regain control over him. It is not going to happen overnight. Maybe she could start with something small…mum*

also seems to be seeking help from friends to ask him to control his temper and thus presenting herself as a weak mum.' The plan included advice such as '*mum needs not to say no if she is going to say yes'.*

13. Psychologist 1 appeared to see signs of ADHD in Gurnam and considered following this up. It seems that the Psychologist 1 found Gurnam difficult. He noted Gurnam refused to go to the waiting room when asked and concluded, *'all in all did not come over as a very likeable boy - something I have rarely come across'*. The analysis will explore current thinking of the links and similarities in presentation between post-traumatic stress disorders and ADHD and the risk of misdiagnoses.

14. At the next session in August, Jeera claimed Gurnam was still swearing at her but not hitting her. Psychologist 1 again criticised one of her responses as evidence of her '*saying things she did not mean'* noting '*she threatened him that if he would hit his mum, she would start hitting him, the way his dad used to do'*. The 'plan' now had been reduced entirely to parenting advice to Jeera. There is no indication that Gurnam was even spoken to at this session.

15. On the final session in mid-August 2005, Jeera was alone. She reported '*significant improvement in his behaviour no hitting, no swearing*'. She assured the Psychologist she had been '*strong'.* The Psychologist repeated the plan that focused on Jeera's response. Jeera apparently had heard enough; the Psychologist recorded, '*mum would like to see another clinician, preferably a Punjabi speaker'*. The impact of the attitude of professionals upon parents experiencing CPA will be considered in the analysis.

16. The practice during this period (2003 to 2007) showed little appreciation that Gurnam posed a considerable risk to others, as well as to himself. Instead, there was a preoccupation with setting boundaries.

4.3 The second period of CAMHS Involvement with the family: September 2007 to February 2008

1. In early September 2007 (13), Jeera's daughter Deepika (10) attended a neighbour's address in late evening with a piece of paper with the details of their doctor asking for the neighbour to call a doctor for her brother Gurnam, as he had beaten up her mother who had locked herself in the bathroom. The neighbour called police and upon officers' arrival, they spoke with Jeera who said that her son, Gurnam, had punched her and hit her with a belt; officers saw that she had swelling under her left eye and welts on her arms. Gurnam was present and arrested for S47 Assault whereupon he said to the arresting officer '*I did not beat her, I hit her'*. Jeera gave a statement saying she did not want to discuss the matter or go to court and would not confirm that she had been assaulted. A consistent feature in this case was that Jeera apparently wanted to support her son, not criminalise his behaviour. She always hoped according to Deepika that Gurnam would '*grow out of his violence and aggression'*.

2. The decision was made for 'no further action' in relation to Gurnam, since his mother would not make any kind of complaint and that there were no other witnesses to the assault. WMP have since destroyed paper records from this period but prosecution of a juvenile without the support of the victim, particularly where that victim was a parent, would have been unlikely at that period.

3. The Children's Trust IMR identified that WMP referred concerns to Children's Services because Jeera wanted support. The case was closed quickly, and there are no records available of any involvement with the family.

4. Immediately following this episode, the family GP re-referred Gurnam to CAMHS. They were screened promptly in late September 2007 (13).

5. The assessment started by identifying '*hitting mom and sister'* Gurnam is recorded as wanting to buy a knife because his mother had hidden the kitchen knives to prevent him hurting himself or others. Jeera explained that Gurnam had spoken about ending his life. Psychologist 2 noted that Gurnam used the F-word repeatedly and was hard to understand. Gurnam insisted his mother should buy him a gun and knife to shoot birds. The professional again identified a lack of boundaries being set by Jeera because Gurnam kept interrupting her. Gurnam was apparently still sleeping in his mother's bed. There was no consideration of the risk that was posed to Deepika and no safeguarding referral. If the recent police arrest of Gurnam and the injuries suffered by Jeera were discussed, it was not recorded in notes. This seems a very unfortunate omission from the perspective of assessing risk to Jeera and Deepika.

6. In November, Jeera reported a '*90% improvement in hitting behaviour'*. The emphasis became almost exclusively Jeera's parenting; the consultant suggested Gurnam should be given support for '*anger management'*. There is no evidence this occurred, or the referral was even made.

7. In December 2007, Jeera attended CAMHS unannounced, asking for help and, since the assigned Psychologist 2 was on leave, Jeera saw a female professional, Psychologist 3. She reported now that hitting behaviours against both her and Deepika had continued for the past 3 to 4 months. Gurnam had apparently put a belt around his neck in September. 2-3 days before he had talked about killing himself. Jeera said Gurnam was sensitive to noise and slept poorly, but with no visual disturbance. Jeera was asked to bring Gurnam in the next day, but Jeera made it clear she was anxious that she would be hit by Gurnam for arranging an appointment.

8. At the CAMHS appointment next day, Gurnam spoke '*passionately'* about his wish to have a gun and knife. Gurnam's agreement to attend the session had apparently been secured by Jeera promising to buy him a knife. Psychologist 3 recorded '*doesn't see anything wrong in beating mum, sister peers up'.* He

spoke openly about '*beating the "shit" out of a pupil 2 weeks ago*" Psychologist 3 noted that Jeera had visible injuries, old and new and superficial knife wounds.

9. Apparently for the first time a professional, Psychologist 3, recorded telling Gurnam not to hit his mother and sister. She recognised the need for a psychiatric assessment, because of '*the level of violence and serious intent'.* The assessment was carried out urgently the next day.

10. The concern was shared with Children's Services and it was made clear that the risks were to both Jeera and Deepika. No action was taken by Children's Services on the basis that the referral was a '*behavioural*' matter and Gurnam had been referred to CAMHS. No mention of the identified risk to Deepika was made in available notes. This was poor practice and left Deepika and the family at risk.

11. During the Psychiatric assessment, with Psychiatrist 1, Gurnam described an episode where he had beaten a fellow pupil, causing a broken nose and bruising. He also referred to his arrest for assault of his mother. He explained he '*couldn't stand*' Deepika's screaming when he assaulted his mother. In her consideration of Gurnam's mental health, Psychiatrist 1's notes state; *'not psychotic – insight'.*

12. During a review in early January 2008 with Psychologist 3, Jeera described only a couple of violent episodes, both linked to Gurnam being challenged for spending hours on his PlayStation game. Gurnam again spoke of wanting to kill his dad. Psychologist 3's assessment was: '*Gurnam's ego development is vulnerable hence his level of anxiety and need to control all within the family home. Mum is trying to improve but her interaction to date have given Gurnam the message that he is all powerful and she is so weak. Mum then gets pushed so far that she reacts which comes across as sibling dispute rather than parental discipline.*'

13. It is noteworthy that all subsequent CAMHS contacts with the family were with Jeera alone, either in person or on the phone.

14. In early January 2008, Psychologist 2 and 3 held a review with Psychiatrist 1 to discuss how to achieve '*behavioural change'* and '*work with mum'.* They planned to find out what Children's Services were doing for the family. (There is no evidence that CAMHS became aware that Children's Services had immediately closed the case.) The case was returned to Psychologist 2, supervised by Psychiatrist 1.

15. Reviews occurred in January 2008 with Jeera, alone. She also cancelled some appointments. She noted Gurnam was drinking alcohol with friends was threatening her and swearing but not hitting her. Psychologist 2 planned a pre-emptive referral to the Youth Offending Team because of fears relating to potential criminal activity but Jeera refused this service before Gurnam was discharged from CAMHS.

16. Jeera stated, in late January, that Gurnam had '*not hit her for three years'*. She reported feeling in control. She described support from the Gurdwara. Psychologist 2 noted in records '*denial*'. She was contacted by Psychologist 2 regularly but cancelled an appointment with Psychiatrist 1 because Gurnam '*didn't want to come'*. She described the '*wonderful service'* she had received from Psychologist 2. After repeated positive feedback from Jeera, Gurnam was closed to the service at the end of February 2008 (13). There is no evidence he attended in person for a review before the case was closed.

17. It was Deepika's view that throughout the family's engagement with CAMHS, her mother would not have minimised the abuse or violence that Gurnam was perpetrating; but because she was often not assisted to express her views in her first language through an interpreter, she may have been misunderstood or misquoted. It is the view of the Chair that Jeera also may have felt a degree of shame at her apparent inability to set boundaries and may have consequently felt pressured to identify improvements in Gurnam's behaviour that were in fact temporary.

4.4 The third period of CAMHS involvement: Gurnam becomes a Looked After Child (LAC) January 2010 to July 2010

1. In early May 2009 (14), Children and Young Persons Services (CYPS) received a report of concern via the National Society for the Prevention of Cruelty to Children (NSPCC), for Jeera and Deepika (12). It was from a family friend, who was reporting Gurnam was being physically and verbally threatening to them both. CYPS awaited an update from police, which did not appear to happen and CYPS took no further action. This was poor practice; their own records showed a previous history of five referrals.

2. In early January 2010 (15), Gurnam's GP re-referred Gurnam to CAMHS. He wanted the referral expedited because there had been an attack by Gurnam on Jeera causing '*superficial injuries caused with a knife'*. Gurnam had taken to night-time wandering in cemeteries and was 'fixated' with demons. An appointment was set for early February. There is no evidence the assault and injuries were reported to Police nor any record that this was a choice made by Jeera herself. No child safeguarding was considered.

3. During this period Gurnam apparently began to drink and used illegal substances with friends.

4. In late January 2010 (15), Deepika (12), sister of Gurnam, called 999 saying Gurnam had mental health issues and had punched their mother Jeera to the face. The West Midlands Ambulance Service (WMAS) and West Midlands Police (WMP) were informed, and officers attended along with paramedics. Gurnam was arrested, and it became apparent that a language barrier required an interpreter to allow officers to communicate effectively with Jeera, who did manage to tell officers that she did not want her son

prosecuted. It was stated that there were no witnesses apart from Deepika who was, according to the WMP IMR, unwilling to provide a statement to police. (In conversation with the Chair, Deepika does not recollect being 'unwilling', however it is very unlikely Police would base an evidence-led prosecution on testimony given by a child, where a parent has declined to substantiate an allegation.)

5. Jeera had a small cut to the inside of her mouth and the left side of her face was slightly swollen, however she refused to have any pictures taken or medical treatment. Social services out of hours were contacted and a social worker requested to attend as appropriate adult for Gurnam, as was a solicitor.

6. After arresting Gurnam, officers returned to Jeera with an interpreter, but she said she didn't want to get Gurnam into any trouble and was unwilling to make any complaint or attend court.

7. Jeera informed police via the interpreter that she was at home with her son Gurnam who had just washed his hair and whilst she was in the living room called to him that he should get his hair dry, but he didn't listen to her on the first two occasions. When she called him the third time, she heard movement as if he was moving to go to her and she then heard a sound that made her think that Gurnam had fallen. She began to go upstairs to him and he was walking down; she asked what happened and he got angry and punched her to the face before telling her that he was going to kill her. She told him to calm down and started walking down the stairs, telling him to follow her which he did.

8. There was an exercise push-up bar in the living room which covered the distance from one wall to another; Gurnam tied one end of the belt around his neck and the other on the push up bar and then told her that he was going to kill himself. Jeera then told him to join her in the garden and after staying there for two to three minutes she told him to go back in the house.

9. At that point Gurnam told Jeera to go to her room, that he would go to his, and that he was going to kill her that day. Jeera then put her hand in through the doorway into Deepika's bedroom and signalled Deepika to go, telling her to go to the toilet and then telling Gurnam to let her go. Deepika left and called the police from a neighbour's house. Jeera and Gurnam went back into the living room and Gurnam began swearing at her and said he was going out; Jeera told him that she didn't want him to go out by himself and that she would go with him. Gurnam refused, stating he wanted to go out alone and repeated that he was going to kill her. Jeera also said that two years previously Gurnam had told her he was going to kill her, himself, and Deepika. In relation to the current incident, Jeera stated that when Gurnam said he was going to kill himself, she got scared of him doing something and that's why she wanted the police there; Gurnam also told her that he was going to burn the house down. Jeera told officers that she wanted doctors to assess Gurnam and that he should get medical help.

10. She said that she didn't want him sent anywhere else, knew that he was mentally ill, and did not want him to go to prison. She wanted 'doctors from the police' to check him; she did not want her photo taken and did not want to appear in court. The arresting officer gave a statement witnessing the injury to Jeera and being told by her that Gurnam has mental health issues and had an appointment in February 2010 at the Sandwell Child and Adolescent Mental Health Service (CAMHS). Gurnam told the officer that he got angry, threw things at his mother and punched her to the face.

11. Following his arrest and once in custody, Gurnam stated he felt depressed. Gurnam stated he wanted to hang himself. He was seen by a doctor whilst in custody and declared fit to be detained and interviewed. Gurnam was bailed for intervention by the youth offending service, however it is recorded that he failed to engage. Ultimately the decision was made to locally resolve the matter via apology in the absence of support from Jeera for prosecution and 'in accordance with her wishes'.

12. The decision by Jeera does not appear to have been reviewed in the light of ongoing risk to her and Deepika. There was no recorded evidence of any safety planning, which would be best practice where an adult retracts her statement or will not substantiate the allegation made. In the context of police awareness of CPA in 2010, this did not appear to be an active consideration.

13. Gurnam was reviewed at the beginning of February 2010 (15) with Jeera present at CAMHS with Psychologist 4, a Punjabi speaker, but with an interpreter present.

14. Gurnam stated he had tried to strangle his mother 2 days before. He was described as self-reporting as calm but was actually presenting in a highly agitated state. Gurnam described his longstanding hatred of his father as the justification for his anger. He was described as not attending school, with very disturbed sleeping patterns sleeping from 6am to 3pm and staying up for 2 days on occasion. He visited graveyards returning with unexplained cuts and bruises. Gurnam referred to having access to a gun and he was making himself stronger to '*kill his father'*. Psychologist 4 actively discussed the risk to Deepika with Jeera and recognised the domestic abuse sharing concerns with Youth Offending and Women's Aid.

15. Psychologist 4 described features of Gurnam's behaviours that were evident in 2010, in a letter to the GP. They were confirmed by Deepika, in her discussion with the panel, as central to understanding Gurnam. Psychologist 4 stated, '*Gurnam lacks self-awareness of the triggers to his anger and complains that people around him have 'problems' while he is perfectly normal'.* Gurnam and Jeera described his sensitivity to light and loud noises. Jeera reported that '*Gurnam hears voices and makes reference to not being human'*.

16. Psychologist 4 considered this could be evidence of psychosis and referred Gurnam to the Early Intervention Team and proposed a psychiatric assessment with Psychiatrist 1.

17. Four days later, the GP contacted Youth Offending services (YOS) because Gurnam had made the same threats to kill his father in an appointment with him. YOS and WMP assessed the concern and shared intelligence with Northamptonshire Police.

18. In February 2010 (15), Northamptonshire Police were aware and investigated the threats made by Gurnam against his father. Jaswinder contacted Northamptonshire Police regarding information he was aware of concerning Gurnam and threats he had made to harm him and other family members; he also stated that Gurnam was involved in gangs and firearms in Birmingham. He was provided with a comprehensive safety plan should there be any contact from Gurnam and an enquiry was sent to West Midlands Police regarding the information provided. The threats were not specified; the West Midlands Police response identified he was known for two assaults on his mother and had no affiliation to gangs or firearms. Intelligence logs were completed (threat danger report) and submitted regarding the information. No further issues were reported.

19. The Early Intervention Team (EIT) assessed Gurnam in his home in mid-March 2010 (15), he denied being violent but admitted being threatening and aggressive.

20. Late in the evening on the same day in mid-March 2010 (15), Gurnam was arrested to prevent a breach of the peace after officers were called to the family home as Jeera and Deepika had locked themselves in a room because Gurnam was becoming violent. Upon officers' arrival, the house was in darkness and Jeera opened an upstairs window and dropped keys down to the officers, so they could gain entry. Whilst in custody Gurnam was seen by a doctor who declared him fit to be detained. The next morning Gurnam was released into the care of Jeera; it was recorded she was happy to have him back and was taking him to an appointment at CAMHS that day. There is no evidence of any child protection response related to Deepika or safety planning of any sort.

21. EIT proposed in the last week of March a multi-disciplinary meeting with the school, who agreed to refer concerns for Deepika. Independently of this, Children's Services recorded a Management Decision after the case was allocated to SW1. It outlined a list of required actions for the SW1 which included the need to assess the risks posed by Gurnam; any safeguarding issues for anyone else in the household; the need for liaison with other agencies including YOS and CAMHS and the need to consider whether a Core Assessment was required to look in more depth at support needed for Gurnam and the family.

22. Three days later Psychiatrist 1 and EIT visited Gurnam at home for an initial assessment.

23. At the end of March 2010 (15), Jeera attended a police station asking to speak to an officer regarding a problem with her son Gurnam, whom she said was taking drugs and assaulting her. It was ascertained from Jeera that Gurnam had been on Class A drugs for the last three months and whilst under the influence had assaulted her. It is stated that Jeera was staying with relatives. Due to a language barrier, an interpreter was arranged to obtain a statement from Jeera that same day and it was then learned that she was not reporting an assault and what she described was from a previous incident already dealt with. The police made a record of the concerns, but the outcome of this report is no longer available.

24. In mid-April 2010, Jeera reported to Children's Services her concerns for the safety of Deepika and herself. She described all the vulnerabilities and the fact that Gurnam had broken locks in the house suggesting that they could not get away from Gurnam.

25. Deepika was visited at school by Social Worker 1. She disclosed witnessing her brother '*hit, kick and punch'* their mother. She disclosed that she and her mother slept in the same room behind a locked door and that they had had to hide the knives and scissors for fear of what Gurnam could do with them. Deepika disclosed that Gurnam had hit her in the past, but she did not have any current marks. She said that he had previously cut her with a knife and that her mother had lots of old injuries and scars from Gurnam. The outcome of this visit was a telephone call from the Social Worker 1 to mother and agreement that Deepika would go to stay with a friend whilst the issues were considered further.

26. The Children's Trust IMR concluded this was an important development but pointed out recognising Deepika's vulnerability was long overdue; '*this was the only point that Deepika was spoken to and her position within the family, either prior to this or any continued risks to her of any further exposure to harm after Gurnam was discharged from Local Authority care, was not considered. The absence of a full assessment means that the only judgement that can be reached in this review is that this was a missed opportunity to fully understand and reflect on the risks and any protective support that Deepika needed.'*

27. Three days later (15), Psychiatrist 1 and EIT visited Jeera and Gurnam with an interpreter and SW1. The social worker was encouraging Jeera to press charges against Gurnam. For his part, Gurnam insisted there was nothing wrong and left the home. An ICPC was being planned to remove Gurnam from the home because of the risk he posed to Deepika.

28. At this point (15), WMP reported a call from Gurnam's school to police; it was stated that there were concerns for Gurnam's attendance as well as him having disclosed taking drugs. Furthermore, there were concerns that Jeera experienced domestic abuse from her ex-husband and that Gurnam's conduct could be learned behaviour. It is recorded that the Early Intervention Team had already assessed Gurnam and he showed no signs of mental illness. Due to the passage of time and lack of available records, no further

information is available. It is of note that the family GP was so concerned that he made three house calls that day until he saw Jeera and Gurnam at around 7pm - Gurnam was described as '*looking vacant'* and '*blaming his mother'*.

29. Children's Services wanted Jeera to sign an undertaking that Deepika would not return home until the issues with Gurnam were concluded, but Jeera argued this was impractical, so Children's Services planned to accommodate Gurnam.

30. At the end of April 2010, there was a joint visit by SW1 and Psychiatrist 1 who was present due to continuing concerns about the behaviour of Gurnam. She reaffirmed the opinion that Gurnam did not have a diagnosed mental illness. SW1 recorded that Jeera was '*failing to protect'* her daughter due to not reporting incidents to the Police. Gurnam did not want to go into care and offered to go and stay with a male friend. Jeera was opposed to this as she said this was a male she believed gave Gurnam drugs. Details of this male were not obtained at this time. Following discussion with Gurnam, he agreed to view the residential unit. After completing the visit, he agreed to move there and was allowed to go home to collect belongings with a view to moving to Children's Home 1 the following day.

31. Gurnam was a Section 20 Children's Act Looked After Child (LAC) for 82 days, during which time he turned 16. The period Gurnam spent in Children's Home 1 appeared to offer respite to Jeera and Deepika but there was no evidence of therapeutic work being undertaken with Gurnam. It appeared to be simply a 'holding exercise'. The Sandwell Children's Trust IMR was justifiably critical of the absence of scrutiny of Gurnam's activities during the period.

32. His regular pattern was to sleep in late, spending occasional days around the unit, or days out of the unit and then go out later in the evening and often not returning until the early hours (ranging from 11pm – 5am). There were occasions when Gurnam would leave the unit very early and then be away from the unit all day. There were occasions when Gurnam would go in and out of the unit late at night for periods of no more than 15 minutes but on several times during a night. Gurnam did not tell staff where he was going and there are no records of any attempt by staff to elicit information from Gurnam about where he was spending time; who with and what activities he engaged in.

33. Gurnam was only reported missing twice by Children's Home 1 and, on one such occasion, was found by Police at the home of a friend, who had been specifically identified to ASC by Jeera as a cause of concern, and possibly involved in drugs abuse with Gurnam. On another occasion, Gurnam returned, and his speech was slurred, and he appeared '*spaced out'*. This was not subject to any recorded investigation or challenge by staff.

34. The Independent Review Officer held the appropriate meetings required for a Looked After Child (LAC), and the LAC Mental Health Team and the CPN from the Early Intervention Team, who had assessed Gurnam in his home with Psychiatrist 1 amongst others, were present. There was confirmation that Gurnam was not mentally ill and that he would cease being a LAC and intended to get a job and move in with a friend. This was apparently not challenged. There was no safeguarding discussion relating to Gurnam and his family, and no plan to address Gurnam's needs. Gurnam had not been subject of a core assessment (a statutory requirement for LAC) but this was not challenged or addressed.

35. **Gurnam was sixteen in 2010**

36. EIT discharged Gurnam from the service in mid-June 2010 (16). They had found no evidence of psychosis but apparently the letter to the GP suggested psychosis could develop later.

37. It is not clear whether Gurnam returned home or, as he had stated, he spent time with friends. Gurnam had been discharged from Local Authority Care and returned to the care of his mother. However, the Gurdwara remained actively involved trying to support the family and it is clear Gurnam was spending a considerable amount of time there.

38. Late in the evening, on a day in early August 2010 (16), WMAS informed WMP of a report they had received of an assault involving Gurnam at the Gurdwara. Officers attended but the victim said he knew Gurnam and didn't want to make a complaint; the victim was an adult male who received an injury amounting to a one and a half inch cut above his left eye. He provided a statement but refused to make a complaint or attend court. He told officers that he had known Gurnam for a couple of months and had been teaching him to read prayers at the temple.

39. He said that he had met Gurnam at the temple, and they conducted a short lesson for ten minutes during which Gurnam seemed very happy and attentive. After the lesson they both went into the main temple hall for evening prayers.

40. That night, he was intending to sleep in the guest room at the temple which is a small room in which there were a few bookshelves and mattresses on the floor. They went to the guest room for another ten-minute lesson but discovered a visiting priest was asleep. He told Gurnam they would get the book they needed and conduct their lesson downstairs, as the hall was now quiet. As he and Gurnam entered the guest room, they left the light off so as not to disturb the priest.

41. Without warning the victim was grabbed from behind by Gurnam in a bear hug, both arms wrapped around his chest, and '*the squeeze was so strong it knocked the breath out of him'*. Gurnam then let go

of him and hit him three times to his upper back, after which he turned to face Gurnam, who then struck him to the left eye three times.

42. The priest awoke and rushed over and grabbed hold of Gurnam, pushing him away; Gurnam reacted by picking up a hockey trophy and hitting the priest on the forehead with it. The priest then picked up a quilt and held it in front of him to try and prevent Gurnam from striking him further. Gurnam then dropped the hockey trophy and ran out of the room and down the stairs leading to the main hall.

43. It was not known what caused the sudden change in behaviour as Gurnam showed no signs of aggression in any way and the victim maintained that he was unwilling to make a complaint of assault or attend court as he felt that Gurnam was a very troubled young man desperately in need of help. The visiting priest sustained a cut to his head but also would not make any complaint to police.

44. The next day, officers attended Gurnam's home address where he was arrested. He was seen by a doctor who reported that Gurnam had history of contact with mental health services and recommended a mental health assessment whilst in custody, the result of which was that Gurnam was not mentally disordered and had no acute mental health issues.

45. Jeera was asked if she would be willing to act as appropriate adult but refused stating that she couldn't cope and did not want him back at the address; Sandwell Social Services were contacted, and an appropriate adult arranged as was a solicitor. Gurnam maintained silence throughout his interview and with no complaint from anyone or a witness willing to come forward, along with the absence of CCTV or other evidence then a prosecution could not take place. Gurnam was released into the care of his father, Jaswinder, who still lived in Northamptonshire and who collected Gurnam from custody.

46. It does not appear that when WMP allowed Gurnam to leave with Jaswinder they were aware of, or considered, the child custody arrangements or Jaswinder's history of domestic abuse in relation to Gurnam, Jeera and Deepika. Deepika explained that her mother could no longer cope, and she felt perhaps a male influence may have helped Gurnam. Deepika acknowledged that this appeared a risky decision.

47. In mid-August 2010 (16), CYPS closed Gurnam's case. Gurnam had told them he wanted no more support and would not accept being a Looked After Child. There is no indication that CYPS were aware that Gurnam had already left to live with his father in Northampton. Apparently with Jeera's agreement, Gurnam returned to her care. The CYPS record stated, '*there are no ongoing issues and no role for this service'*. Deepika was thirteen, however there was no indication of any consideration of the risk to her in living with her brother.

4.5 Gurnam moves to Northamptonshire with his father Jaswinder: 2010 to 2013

48. Gurnam lived with his father in Northamptonshire from mid-2010 to early 2013. From September 2010 until 2013 he attended a local college on a computing course.

49. The Northamptonshire Police IMR acknowledged weakness in some of the interventions described in this section. However, they provided extensive details of how such incidents would be responded to today, that provide sufficient reassurance that these historic incidents do not represent current practice.

50. In mid-December 2010 (16), officers responded to a disturbance at Jaswinder's house; he and Gurnam had argued, and it had 'got out of hand' however neither wanted to pursue any form of complaint. Jaswinder went on to provide further information that Gurnam would take a hammer or knife to an area of woodland in the town looking to fight someone and at college was learning how to stab someone to cause the maximum damage. He also had concerns Gurnam had mental health issues, albeit not diagnosed. Intelligence logs were submitted, and intelligence suggests that the day after Gurnam pinned his father down and knelt on his arm to scare him.

51. In early March 2011 (16), Gurnam's paternal aunt contacted the police regarding an assault on her and Jaswinder by Gurnam, who was arrested. He had repeatedly punched his father Jaswinder in the face, his aunt tried to intervene and was punched or pushed. Jaswinder was then tripped and fell to the floor where upon Gurnam picked up a spanner and continued to assault Jaswinder. In his police interview he admitted punching his father but denied using the spanner to hit him. Jaswinder suffered a fracture to his nose during the assault; Jaswinder's sister had no injuries.

52. Two days after the assault, Jaswinder rang the police and stated that whilst tidying Gurnam's bedroom he had found some notebooks that Gurnam had been writing which he found very upsetting. The notebooks were recovered, and the content copied; the content was subsequently shared with Northamptonshire Special Branch and intelligence logs were submitted[5].

53. Following his arrest, Gurnam was referred to the Youth Offending Team (YOT) and released into the care of Northampton Children's Services (NCS) who initially placed him at a hotel, from where he moved to semi-independent living (Hostel) in an adjacent town. He received a Final Warning for the assaults.[6] It is believed that during 2012 he went back to live with his father, Jaswinder.

1. **[5] The referrals were made under the Government's "Rich Picture" programme - intended to promote a better understanding of the extent and risks from radicalisation. There were apparently no on-going concerns related to Gurnam and no further interventions occurred.**
[6] The Final Warning scheme was introduced in 2000 in an effort to encourage young people to take responsibility for their criminal actions and keep them from committing further offences. It replaced the old system of police cautions for young people. The Final Warning scheme was abolished in 2012 and replaced by Youth cautions.

54. Northamptonshire Children's Services (NCS) worked with Gurnam after the assault. He was identified as a child in need under section 17 of the Children's Act and provided with hostel accommodation. He was open to the service between March and November 2011. The NCS IMR noted a failure to carry out a Core assessment and other procedural irregularities which reflect poorly on practice at that time. There was, for example, little awareness of his time as a LAC in Sandwell. The case, which was complex, was allocated to a newly qualified social worker. (The NCS IMR identified positive changes as well as robust recommendations that would mean the same failures would not occur today.)

55. In relation to Gurnam and his father's relationship, there was supervised contact which highlighted several worrying concerns shared by Jaswinder, regarding Gurnam's behaviour. These were focused on his possible association with drugs, possible purchase of weapons and on-going fears that Gurnam was a threat to him.

56. It is worth noting that Jeera engaged with NCS, asking that a mental health assessment of Gurnam take place. In addition, she raised concerns that Gurnam had been 'sighted' by her and Deepika twice, outside at her home, although this was denied by Gurnam. He stated he wanted '*nothing to do'* with his mother and sister.

57. Gurnam was referred to CAMHS; however, this referral was not accepted, and it was recommended that Gurnam sought support through his GP. This action was not followed through or supported by his father or support worker. The Northampton Children's Services (NCS) IMR noted '*Given the worries about his aggressive behaviour, concerns raised by both of his parents at the time and historic violent events, along with Gurnam's interest in witchcraft, an understanding of Gurnam's mental health would have informed a risk assessment. It is understood that this was not progressed because it was accepted that Gurnam did not want an assessment, as he felt he would "pass any assessment"'.*

58. In October 2011, when Jaswinder reported to the allocated worker that Gurnam had purchased a knife and an axe, the worker recommended Jaswinder report this to Police. The next day, the worker reported this to the hostel and a room check was completed but no weapons were found. It is not known whether Police were contacted.

59. The NPS IMR correctly described the level of engagement with the family as weak. '*The assessment of Gurnam and his family, both as victims and perpetrator of domestic abuse, was absent in the case review. In addition, Gurnam's allocated worker was not qualified although the worker was supervised by a qualified social work manager*. *Information presented was taken at face value, and there was too ready acceptance of progress being noted, without investigation of concerns shared by the victims – Gurnam's*

parents. It is possible that, due to Gurnam's parents living in different counties, agencies did not share information effectively.'

60. **Gurnam was eighteen in 2012**

61. At the end of January 2013 (18), Gurnam was arrested for an assault on Jaswinder and threats he had made to his grandmother and other family members over a two-month period. Gurnam and Jaswinder had argued because Jaswinder refused to take him for a driving lesson. He initially calmed down but then unexpectedly grabbed Jaswinder in a choke hold; he released him only when his (Gurnam's) watch fell off his wrist. After releasing Jaswinder, Gurnam started kicking his father, who subsequently ran to a neighbour's house and called the police. Two weeks earlier, Gurnam had set fire to one of Jaswinder socks whilst he was wearing it. Gurnam's grandmother stated that over the previous two months, Gurnam had threatened to kill her and the family. He was arrested and interviewed but made no comment in relation to questions asked of him. The Police recovered '*a large number of knives*' from Jaswinder's shed.

62. Gurnam was charged with harassment offences. In July 2013 (18), Gurnam was sentenced at Magistrates' Court and given a 12-month suspended sentence order requiring 12 months' supervision and 200 hours of unpaid work. He ultimately returned to the West Midlands.

4.6 Gurnam returns to Sandwell: July 2013

1. Gurnam returned to the West Midlands and was supervised by National Probation Service (NPS) in Sandwell. He was living with family friends. The Court did not request a pre-sentence report, but the court are at liberty to do this. The NPS noted that had a report been prepared '*this would have facilitated potentially a greater overview of risk, from other agencies*'.

2. Probation noted that Gurnam was evasive about his home address, and there was no verification of who he was living with. The Offender Manager accepted Gurnam's account, rather than undertaking a home visit to verify arrangements. (There has been a subsequent change of NPS policy to ensure more home visits are undertaken.)

3. NPS records show a request to Sandwell Children's Services to provide them with Gurnam's child protection history, which was apparently not provided. Sandwell Children's Services, for their part, have no record of this request being made by NPS. The DHR was satisfied that no barrier existed at that time, between Sandwell Children's Services and NPS, to prevent information sharing for the purpose of safeguarding. However, Gurnam was not believed to be in contact with his mother and

sister and this was not a risk that NPS were actively assessing. On the OASys[7]system he had been assessed as a medium risk to others based on past offending. Throughout the period of supervision, NPS made several requests to police to monitor domestic abuse call-outs at several addresses involving family members, and this information was considered in the risk assessment.

4. An initial supervision plan was drawn up in early September 2013 with interventions designed to manage risk and target the factors that underpinned his offending behaviour. These were identified as '*work around his propensity to resort to violence, development around the impact his behaviour would have had upon the victim, intrafamilial conflict work, work around improving employment opportunities and securing employment going forward and completion of his unpaid work hours'.*

5. It is unfortunate that the violence that Gurnam had perpetrated against his father and other family members was not flagged on the probation system as domestic violence. Similarly, there was no flag put on the system. The OASys highlights the risk to family members and all risks were considered. Whilst the DHR would accept that NPS practice at the time was not appropriate, the 2004 Home Office definition *"Any incident of threatening behaviour, violence or abuse (psychological, physical, sexual, financial or emotional) between adults who are or have been intimate partners or family members, regardless of sexuality."*[8] would include Gurnam's offending. The Offender manager spoke with Gurnam in October 2013 and therefore had a full history of concerns around Gurnam, including his alleged use of Class 'A' drugs. Although this was discussed with Gurnam and denied, the fact that drugs had not been involved in the offending in Northamptonshire would have limited the scope for work in this regard.

6. National Probation Services ceased supervision of Gurnam in June 2014.

7. In October 2014 (20), Gurnam was provided with hostel accommodation by a housing association which was for young people 18-25 years old. In a new resident assessment, Gurnam spoke of relationship breakdown with his father. There is no clear evidence that Trident knew of his offending in Northamptonshire although they recorded, he was historically violent. Gurnam was identified as having '*severe stress and violent ideas'*.

8. His engagement with support in this period was inconsistent; he received a warning related to missed appointments. In a meeting in March 2015, Gurnam said he was in contact with his father but did not want to see his mother. He claimed to be avoiding friends and associates who he felt would lead him

2. [7] OASys is an integral part of the work probation officers do in assessing offenders; identifying the risks they pose, deciding how to minimise those risks and how to tackle their offending behaviour effectively. OASys is designed to help practitioners to make sound and defensible decisions.

[8] Home Office, Domestic Violence A National Report, March 2005

into criminal activities. A month later, he said he was now in contact with his mother and visiting regularly. He reported failing in his assessment for the Army in September 2015.

9. At the supported accommodation they reported Gurnam was accused of homophobic insults during a BBQ. In late October 2015, Gurnam reported to police being racially abused by his neighbour. The investigating officer made attempts to progress the enquiry but, in January 2016, Gurnam informed the officer he had now moved to address 1 and was no longer interested in pursuing the allegation which was therefore filed.

10. Gurnam left Trident in January 2016 and it appears he lived with friends. However, in September 2016, Deepika started at University and Gurnam moved into home address 1 in around October/November 2016.

4.7 Gurnam returns to live with Jeera: October/November 2016

1. Deepika stated in conversation with the panel that she was deeply unhappy with this arrangement but knew she would not be able to persuade her mother not to offer her son a home. It was Deepika's view that Jeera hid from her the extent of Gurnam's abusiveness during this period, however it caused her real anxiety which she shared at the time with her friends and boyfriend. She feared daily for her mother's safety.

2. On an afternoon in late February 2017 (22), Jeera called 999 saying her son was abusing her, swearing and hitting her and had punched her in the stomach. She stated that he did this every day and was still in the house. Officers were despatched immediately, at which point they spoke with Jeera who stated she had been kicked by her son to the stomach; she was holding her stomach and crying. Gurnam was in his bedroom at the address and arrested on suspicion of assault.

3. An interpreter was taken to see Jeera who told officers that she was not willing to make a statement against Gurnam because she wanted to give him one chance to improve his behaviour she said that she would not assist the police in any prosecution against him and would not attend court. Further, Jeera refused to complete DASH.

4. Gurnam was interviewed without legal representation at his own request and said he moved back in with his mother in November 2016 as he was ill and had nowhere else to stay. He said he was having issues with his kidneys and was in a bad way, and that his mother swore every day and blamed him, telling everyone that her life had been ruined. He said she was not a nice person and had used people all her life. He said he had not argued with her that day and had not kicked or punched her. Gurnam said Jeera

was a compulsive liar and that he believed she had said these things, so he had to leave. Gurnam was asked if he had anywhere else to stay and he said he would get a hotel room.

5. Jeera was spoken to with an interpreter and asked to provide details about what happened leading up to her call to police but she refused to engage, provide a statement, or cooperate with a risk assessment. She stated she had no injuries and none could be seen by officers. Jeera was informed that without her support the likely outcome was no further action and she was happy with this, stating she wanted her son back home. Jeera refused all offers of referrals to partner agencies. With no support from Jeera and no witnesses, visible injuries or other supporting evidence, there was no realistic prospect of conviction and Gurnam was made subject of no further action.

6. During the interview for assault, Gurnam made a counter-allegation and disclosed that Jeera had sexually abused him when he was a child. He said he had never told anyone before as he had been too ashamed, but he needed to get it out of his head. The matter was investigated the following day.

7. The DHR was provided with a comprehensive, detailed account of the allegations and of a Police investigation which was proportionate and thorough. Gurnam said that he wanted the police to help him find a home; he was signposted to Sandwell Council. He was advised to speak to his GP, because he said he had constant thoughts of what happened to him. Police made repeated attempts to contact Gurnam in March and April but had no contact from him and the matter was filed. Jeera was not interviewed and was probably unaware of the allegations.

8. The DHR noted that Gurnam was given every opportunity to pursue these allegations but chose not to. It is recognised that disclosing sexual abuse as an adult is a difficult and emotional process and many victims chose not to proceed but carry with them the impact of abuse for their entire lives. However, the allegations do need to be taken in the context of the family history.

9. Gurnam chose to re-visit these allegations in his defence, together with a self-defence claim, at his trial for the murder of Jeera and Amrinder. They were all described by the prosecution as ‘pure fantasy’ and the jury, in convicting Gurnam, agreed. The DHR was provided with no evidence that gave any credence to the sexual abuse allegations.

10. In mid-July 2017, Jeera called 999 and said that Gurnam was abusing her every day and had now hit her. Officers were despatched. Upon officers’ arrival, they spoke with Jeera who said that Gurnam was often verbally abusive towards her and that day, during an argument over rent, Gurnam elbowed Jeera to her back, causing pain and discomfort. Gurnam was in his bedroom and was arrested. When officers returned to the address after presenting Gurnam to custody, Jeera told them that she would not provide a

statement of complaint nor support a prosecution. Jeera was offered referrals to partners but declined any such support; Jeera was given a contact card with details of the National Centre for Domestic Violence.

11. Jeera had no visible injuries; there were no witnesses or other evidence to support an assault such as CCTV. Jeera did complete a DASH with officers in which she indicated that she was frightened and feeling depressed because of the situation; she stated that Gurnam was swearing and shouting at her every day and this was the worst incident to date.

12. A supervisor updated police records to say that Jeera was offering no evidence against Gurnam and had no injury; there was no sign of disorder at the address and there were no witnesses to the incident. In the absence of a complaint or evidence against Gurnam, WMP took no further action. Jeera did not meet the threshold for referral to the Multi Agency Risk Assessment Conference (MARAC). The support offered to Jeera would have been once more to Domestic Abuse services. This did not offer a solution to the ongoing risk posed to her by her adult son.

13. Jeera and Amrinder had met in 2017 and, by 2018, Jeera had moved out of family home 1 and was living with Amrinder. Gurnam stayed at family home 1 and there was limited contact between them. It appears that Gurnam was working at a local supermarket and had little contact with professionals including his GP.

14. In November 2018, Gurnam called 999 stating he wanted to know something about knife crime and asked, '*if someone comes at you with a knife, what defence can you use, and can you hit them?*' Gurnam was asked if he was in any danger at that moment; he said a couple of fights happened in the past, but he had not received any threats recently. He was advised that 999 wasn't the appropriate line for that conversation but if he was ever in that situation, he needed to call police and could use reasonable force in self-defence. The log was then closed.

15. Gurnam was to attend the GP several times in 2019 concerning stress and anxiety. In May, a mental health assessment raised no new concerns. The GP noted that after an out of hours consultation at this time, Gurnam gave his address as HMP Winson Green. This claim was not subsequently explored by the GP with Gurnam, and therefore it is unclear why he chose to give this puzzling, fictitious address.

16. In mid-June 2019, Gurnam attended A and E on two successive days relating to bite wounds to his right arm and hand, which required suturing before he was discharged. Gurnam stated that he had no recollection of the cause, due to consuming 2 litres of whiskey and cocaine the previous night. When Gurnam presented to ED in June 2019 on successive days after abusing alcohol and drugs and sustaining

an injury (of which he had no memory) the SWBFHT IMR noted; '*there seemed to be no consideration of the impact of his behaviour on family members or in fact whether he had any caring responsibilities (either adult or children). This was a missed opportunity to refer on to alcohol services and unfortunate given there are clear pathways of referral in ED; had this occurred Gurnam may have received support in relation to his alcohol and substance misuse. If Gurnam had been referred through to the alcohol team the risks posed by his substance misuse may have provided an opportunity to intervene and explore more fully what was going on in Gurnam's life.'*

17. At the start of July 2019, Gurnam attended the GP with anxiety symptoms feeling panicky and restless. The GP prescribed a trial of Propranolol 40mg. No reference was made to the A and E attendance in June. Three days later, Gurnam attended the GP practice in an anxious state with sweaty palms and complaining of lack of sleep, he was prescribed Zopiclone 7.5mg at night.

18. It is recorded in the GP records that Gurnam made another call to NHS 111 several days later to ask for advice regarding the dosage of Valium he should take. He again gave his address as Winson Green Prison and was advised to not take 40mgs but to contact his GP the next morning. The medication list of drugs prescribed for Gurnam indicates that he had not been prescribed Valium although he had requested it from the GP, the GP had been reluctant to do so.

19. In August 2019 Gurnam called NHS 111 because of a penetrating hand injury and was advised to dress the wound and attend the GP next day. There is no indication in the records that Gurnam followed this advice.

20. A week later, Gurnam rang NHS 111 again to express anxiety and say that he felt his Amitriptyline, which had been prescribed two weeks previously, was not working. He was told to call back if his condition worsened.

21. Early in September 2019, Jeera and Deepika attended the GP practice and expressed concerns in respect of Gurnam. It is documented that they felt that Gurnam was displaying psychotic symptoms, "*talking gibberish*", having hallucinations, "*talking to someone in the air*". The GP advised the family to attend the crisis team at Sandwell A and E. The GP also gave the family contact numbers to arrange a mental health assessment for Gurnam at home if necessary.

22. The following day, Jeera, Amrinder and Deepika took Gurnam to the QE Hospital ED. To secure his attendance, they had told Gurnam a consultant had called Jeera in for some results. In conversation with the panel and in emails, Deepika was clear that this was the only way Gurnam would have agreed to go to a hospital.

23. This however meant that when the family asked the triage nurse for a mental health assessment of Gurnam, he was '*upset and angry'* and non-compliant. The family reported to the triage nurse that Gurnam was behaving '*strangely'* although this was not explored with them. The nurse had been on ED only a few months and had no formal mental health training but had mental capacity training. Gurnam declined to see the Psychiatric Liaison Team and the nurse saw nothing to cause her to consider a lack of capacity in this regard.

24. Deepika is clear the family were not given advice at the hospital on how a 'nearest relative' could apply to the Local Authority to request a Mental Health assessment nor were they given any other advice, other than not to retract any allegation made to police if Gurnam again assaulted a family member.

25. Deepika informed the panel that after this attempt to get an assessment, the family also used the telephone numbers they had been given by the GP to attempt to secure an assessment at home. The phone number was for ASSIST, a Local Authority call centre, facilitating access to Sandwell Adult Social Care services. Deepika and her mother reported that they believed Gurnam to be suffering schizophrenia and that the CRISIS team had advised them to contact ASSIST, to request a Mental Health Assessment. The call handler stated that if Gurnam had capacity and was not consenting, a GP would need to request an assessment. When Deepika explained that Gurnam would not go to the GPs, it was suggested they arrange a home visit. The call handler did not advise the family of the nearest relative rights to request a mental health assessment under section 13(4) MHA 1983.

26. At the time the family, were unaware of the exact nature of their rights under section 13(4) of the Mental Health Act 1983. (see below). If the GP had intended that Jeera, as a nearest relative, should request an Approved Mental Health Practitioner (AMHP) assessment through the Local Authority under this Mental Health Act provision, it was not made clear to the family.

27. Deepika stated that in September to December 2019, Gurnam presented in a broadly similar way and that the family remained concerned about his mental health.

28. In the last few weeks of their lives, Jeera and Amrinder had been encouraging Gurnam to move in with them at family home 2. They were, according to Deepika, hoping to provide stability by offering home cooked food and doing Gurnam's laundry so that he could look for work and get '*his life back on track'*. Deepika doubted that Gurnam had any desire to change or recognise that he had a problem, but also knew her mother would never give up on him.

29. The exact circumstances of the homicide will never be known, because Gurnam chose to claim that Jeera and Amrinder had attacked him and that he had stabbed them both in self-defence. This was rejected by

the jury who were satisfied that Gurnam had fabricated a defence built on what the judge described as '*horrific lies*'.

5 Analysis

5.1 Introduction to Analysis

1. The Review will not focus on historic professional responses, that do not represent best practice in 2021. In relation to the involvement of Children's Services with Gurnam and Deepika, in Sandwell and Northampton, the shortcomings across both services and failure to adhere to then existing policy and procedure in relation to Looked After Children have been detailed in the chronology. The agencies themselves have identified that responses in those years were entirely unrepresentative of current child protection practice. The DHR panel was satisfied with the analysis and evidence provided in their IMRs that this is the case.

2. The detailed chronology has described how every member of the family was subject to the experience and consequences of severe domestic violence. Jeera, Gurnam and Deepika were victims at the hands of their husband and father, Jaswinder. Gurnam's exposure to domestic violence and abuse would apparently cause emotional and psychological trauma that may have led him to resort in childhood to coercive and controlling and violent behaviours against his mother and sister to impose his will.

3. Into adolescence, these behaviours persisted, fully recognised but largely unchallenged and unaddressed. As an adult, Gurnam was domestically abusive towards members of the extended family. The anger he had carried with him since childhood, aimed at his abusive father, meant that his father and close relatives, in turn, became victims of domestic abuse.

4. It is a concern to the DHR that a detailed psychological assessment (released to the DHR by Deepika) which had been carried out as part of custody proceedings in late 2003 and 2004, and which was presented to court in February 2004, neither apparently informed nor was a catalyst for CAMHS involvement in 2005.

5. The Psychologist had worked with each family member and offered valuable and detailed analysis of the likely causes of Gurnam's behaviours. The Psychologist stressed the need for family centred therapeutic work, but this did not appear to be initiated by the Family Court or CAFCASS.

6. The DHR recognised that the key events in this case occurred during a period of evolution in our understanding of the nature and extent of child to parent abuse and the devastating impact it can have across generations. To illustrate what best practice should look like in 2021, it has been necessary to

describe how frequently professionals failed to understand or consider the impact upon a survivor and her family, of complex trauma, caused by severe domestic abuse.

7. The harmful thread that runs through the chronology in this case is one of conscious and unconscious victim blaming. Jeera had experienced injury, humiliation, degradation and coercion and control. Far from being 'weak' (a term used repeatedly to describe her parenting of Gurnam) she had shown incredible strength, to escape her abuser and free her children from the experience of abuse. She lost a home, financial security and family support.

8. Re-building her life in a new community, having had agency taken from her for years by her abuser, she was expected by professionals to know how to respond to a child possibly damaged by adverse childhood experiences caused by his father's abuse. Deepika vividly described the challenge posed by her brother, who had '*no respect for or fear of women'*. Female teachers in Gurnam's primary school recognised this, but still it was seen primarily as Jeera's parenting problem.

9. From the day the family escaped domestic abuse, Jeera supported and loved her son, believed to the end he could and would change, but blamed herself for his behaviours, without being told clearly by any professional, '*this is not your fault'*. No parenting style is perfect, and most parents experience some level of challenge from their offspring at some time. Jeera's self-esteem was probably low after domestic abuse, so the likelihood of self-blame was clear. At the heart of her experience of coercive control with her husband would have been his ability to lay the blame for the abuse on her '*failings'* as a mother and wife. If Jeera need support in finding appropriate parenting strategies, professionals for their part needed to understand Jeera's lived experience.

10. Professionals from several services; GPs and CAMHS, Children's Services, concentrated first on '*poor or weak parenting'*, then on Gurnam's mental health, then tried removal of Gurnam to reduce risk by arrest or voluntary placement in care. Yet Gurnam grew into adulthood still driven by the same harmful beliefs and impulses. Far from agencies working with the whole family to bring it together, it remained fractured and, with hindsight, at fatal risk of harm.

11. Did Gurnam become abusive because of the impact of his **adverse childhood experiences? (section six)** There is no easy explanation and academic opinion is divided. The use of ACEs as a predictor of outcomes does not need to be considered, because those harmful behaviours manifested so early in Gurnam's case and continued until the homicides. The DHR will, however, consider what is known about ACEs and adult outcomes because they inform current trauma-informed care. They are also sometimes linked to child to parent abuse.

12. There was little or no real understanding of **child to parent abuse (section seven)** amongst parents and professionals at the time this case occurred (current terminology had not even been coined). This DHR must therefore identify the '*what not to dos'* illustrated by this case, propose solutions and identify how it could best be seen as a safeguarding issue, in the widest possible definition of the term, encompassing adults and children.

13. The DHR chronology has demonstrated that CPA is very often a child protection issue. Gurnam's sibling, Deepika, was at risk throughout her childhood. Yet it is also an 'Early Help' issue; the behavioural and discipline problems Gurnam demonstrated meant it was unlikely he would achieve positive health and developmental outcomes. His behaviours impacted directly upon his mother's parenting capability. He was both vulnerable but also abusive. The DHR has identified an absence of specific guidance within Sandwell's Multi-Agency Threshold Document on how to properly site CPA within the context of early help needs, where a child is consciously or unconsciously using responses that are abusive to siblings and parents, preventing boundaries being put in place and impacting on their own health and development.

14. The family sought a mental health diagnosis for years, resolute in their belief that Gurnam's childhood behaviours were rooted in mental health problems. Assessed by CAMHS over numerous encounters as not having a mental health diagnosis but the potential to develop psychosis, Jeera and Deepika were clear this prescient assessment had been proven right. They could see multiple signs and indications of psychosis in adulthood. They had been told in clear and chilling detail by Gurnam he would kill them and were fearful for themselves, but also others, but could not find a path through the mental health provision to obtain mental health support for Gurnam. **Supporting families to access mental health services (section nine).**

15. The recognition of partner-to-partner domestic abuse is well established but the DHR identified a failure to see **intrafamilial domestic abuse (section eight);** Gurnam's adult abuse of his mother, sister and later his father, grandmother and aunt as domestic abuse. Deepika said that to the best of her recollection, no one identified what Gurnam was doing to them as domestic abuse, even when he was himself an adult.

16. The misuse of alcohol and substances by Gurnam and the risk from cocaethylene[9] was probably a factor that was not taken properly considered in this case. By his teens, Gurnam was abusing alcohol and using cocaine. This causes the creation of a molecule, cocaethylene, when the liver metabolises alcohol and cocaine. This '*third drug'*, as well as increasing the toxicity of both substances, can increase the desire of

[9] **Druglink: cocaethylene Nov/Dec 2005**

the user for both alcohol and cocaine, increasing dependency. It can contribute to presentations that can have the appearance of psychosis and mental disorder, paranoia, unclear thinking, anxiety and depression. It is possible that Gurnam's presentation in his late teens and thereafter, that appeared to show signs of psychosis, were in fact related to either alcohol and cocaine or sudden withdrawal from either substance.

5.2 The context for the DHR

2003: Gurnam was eight years old when he was first recognised to be abusing and assaulting his mother.

2004: The Home Office definition of domestic abuse is *"Any incident of threatening behaviour, violence or abuse (psychological, physical, sexual, financial or emotional) between adults who are or have been intimate partners or family members, regardless of sexuality".*

In 2010: Gurnam is sixteen.

In 2012: Gurnam is eighteen.

31st March 2013 the Home Office definition of domestic abuse lowers the age at which a child can be a victim or perpetrator of domestic abuse to 16. It includes controlling and coercive behaviours. It describes Child to Parent Violence.

July 2013: Gurnam is sentenced for harassment of his father and grandmother

2015: Home Office Information Guide: adolescent to parent violence and abuse (APVA) was published.

6 The Impact of adverse childhood experiences (ACEs) on adult outcomes

1. The research into Adverse Childhood Experiences (ACEs) has increased awareness of the potential impact that such experiences have on a child and the need for trauma-informed practice. There is a growing understanding of the lifetime impact they can have. This DHR does not need to enter into the debate about screening for ACEs as a preventative measure, which has created the illusion that there are 'quick fixes' to social problems.
2. Gurnam and Deepika both experienced the same well recognised ACEs; they witnessed domestic abuse of their mother by their father, which included physical assaults. Gurnam told professionals he had also been hit by his father trying to protect his mother. They then lived with parental separation and divorce because of that relationship breakdown.
3. The psychiatric report prepared for CAMHS revealed that Jeera stated Jaswinder's violence and domestic abuse intensified when she was pregnant with Gurnam. Current understanding of the impact of domestic

abuse on a baby 'in utero', and during infancy, negates the view widely held at the time that children this young were 'unaware' of domestic abuse occurring around them.

a) Learning point: professionals should be aware of the evidence of the harmful impact of domestic abuse on babies 'in utero' and infants, as well as older children

4. In a recent study of the impact of coercive control and domestic abuse[10], Jess Hill spoke with Wendy Bunston, who works with infants exposed to family violence. She describes the infant's experience, '*they are like sensory sponges, soaking up every interaction in a constant effort to learn strategies of adaption and survival. In a violent home the abuser is a clear source of threat and danger, but to an infant so may be their abused caregiver: if the caregiver is routinely afraid or unavailable, the child soon learns they will not be able to protect them'.* She concludes '*imagine being unable to walk or talk (or even less crawl) and knowing the one person you are utterly dependent on for your survival cannot protect you'.*

5. Jess Hill explains '*when this basic sense of safety is regularly denied an infant and they are denied the safety of emotional connection, they enter a heightened survival mode*. *Their brains are constantly bombarded with chemicals designed to manage fear'*. At this critical time in a child's development neural pathways are developing in the brain and these begin to '*reflect the chaos of their environment'*.[11] The fearful infant's brain will, according to Bunston and Sketchley, '*build restricted pathways that serve the purpose of survival. This can put us on a lifelong hair trigger, our brains trained to react to the slightest hint of perceived danger. Here the primitive, fear processing part of the brain, the amygdala responds to stimuli before the rational parts of the brain have a chance to discern whether the perceived threat is real or not'.*

6. As Jess Hill describes[12], '*infants growing up in this environment, who cannot physically hide, learn to hide within themselves becoming, quiet, rarely smiling or giggling, they do not draw attention to themselves by crying'.*

7. In later years, they become '*behavioural detectives; children in an abusive environment develop extraordinary abilities to scan for warning signs of attack. They become acutely attuned to their abuser's inner states. They learn to recognise subtle changes in facial expression, voice, and body language as signals of anger, sexual arousal, intoxication or disassociation'.*[13]

[10] Jess Hill See What You Made Me Do Power, Control and Domestic Abuse page 153-158
[11] Wendy Bunston and Robyn Sketchley: refuge for babies in crisis
[12] Jess Hill See What You Made Me Do Power, Control and Domestic Abuse page 153-158
[13] Herman: Trauma and recovery

8. Children growing up in a domestically abusive household develop the kind of hypervigilance associated with veterans, usually seen as a '*hallmark of post-traumatic stress disorder'.* This was confirmed in a study by Professor Eamon McCrory at University College London in 2011.

9. In a recent article[14] Professor McCrory made a vital observation on the research to date into the impact of childhood adversity on the brain. '*Brain changes associated with abuse and neglect are evident before mental health problems emerge. This should act as a wake-up call in our efforts to develop preventative approaches-and help children before mental health problems emerge.'*

10. This harm does not have to be permanent, brain plasticity[15] demonstrates that a child can heal the impact of trauma, but it may take '*years of intense work and counselling'*. Very early after family separation, in 2003 (9), the impact of Gurnam's experiences and his presentation led support workers at the Women's refuge in the West Midlands to organise counselling for Gurnam. It is unfortunate that the DHR has not been able to find any information on how Gurnam presented. In the several periods of engagement with CAMHS, the focus was almost entirely on behavioural change; there was very little evidence offered of the kind of support given to Gurnam that would address trauma. Jeera seemed to feel herself challenged in relation to her parenting (this is considered below in section seven). This led her to report improvements in behaviour that meant direct work with Gurnam relating to trauma was not felt necessary.

11. It seems also that the absence of a clear mental health diagnosis in childhood closed doors to the kind of support that Gurnam may have needed. When this was combined with a failure to work intensively on the trauma caused by witnessing domestic abuse, Gurnam was doubly disadvantaged, and it became increasingly likely that his symptoms would persist into adulthood. It is argued that today we have a better understanding of the combination of symptoms children experiencing traumas may display. Importantly, they may be predictive of mental health problems.

12. Childhood developmental trauma was studied in the 1990s by Herman and Van der Kolk. Children who had experienced domestic abuse had symptoms of hypervigilance common to PTSD but also a 'laundry list' of extra symptoms. They were '*needy, reckless, clingy, angry, despairing, chronically ashamed or suicidal'.* They often felt utterly disengaged or disembodied. Jess Hill describes how '*no single diagnosis could describe their condition; instead, they were diagnosed with a mixed bag of PTSD, bipolar disorder, depression and especially borderline personality disorder'.*

[14] Professor Eamon McCrory Childhood adversity and the brain: what have we learnt?
[15] brain plasticity, is the ability of neural networks in the brain to change through growth and reorganization

13. The kind of symptoms Gurnam presented with in the early period of the family's new life, in what should have been a non-threatening primary school setting, should today be seen even more clearly as warning signs that Gurnam could develop mental health problems.

14. Professor McCrory, in the article quoted above, identifies childhood '*latent vulnerability'* to mental health problems. The adaptive brain changes, that allowed a child to survive in an 'unpredictable or dangerous home environment' (described above), increase the risk of mental health problems. He describes how these changes contribute in three ways to this vulnerability.[16]

    - S*tress susceptibility* being on 'high alert', makes everyday life more stressful, leading to chronic stress responses even affecting the functioning of the immune system.
    - *Stress generation* - increasing the likelihood they will experience future stressful events
    - *Social thinning* - brain changes after abuse impacts on everyday relationships - reducing social support even into adulthood. Changes in the threat, reward and memory systems may make it harder for children to build and maintain relationships.

15. In adulthood Gurnam abused alcohol and drugs although the extent of this abuse is hard to quantify. In a hospital presentation in June 2019, eight months before the homicides, Gurnam spoke of taking cocaine and drinking two litres of whisky. Exposure to ACEs has been found to quadruple the risk of mental health problems and problematic alcohol misuse.[17] ACEs have tended to be seen as having greater impact the more separate ACEs the child experiences. The 'dosage' of ACES has been shown to have a correlation with outcomes. The findings of this DHR would suggest that one intense experience of adversity may be sufficient to lead to lifelong harms, if not tackled early.

16. The last question may be why did Gurnam apparently suffer so badly and Deepika cope rather better? Deepika herself acknowledged that she had needed help, and her '*brilliant'* GP obtained counselling support which she engaged with, without reservation. There is strong evidence that trauma informed practice mitigates the impact of ACEs.

17. However, there was a very real cost for the resilience Deepika apparently showed. She and her mother were revictimised by her brother's abuse. It seems that Deepika was 'wise beyond her years' and gathered strength from supporting her mother. She described herself as 'parenting' her mother, which left her drained and needing school as a release from home. Deepika learnt to '*self soothe'* to mask her distress from her mother.

[16] Professor Eamon McCrory Childhood adversity and the brain: what have we learnt?

[17] Adverse Childhood experiences - what we know, what we don't know and what should happen next, Early Intervention Foundation

b) Learning point: In assessing the needs of a child, Practitioners should consider that a child may mask their distress, to 'shield' other family members from its impact.

18. It is not surprising Deepika was glad for the opportunity afforded by University to stop dealing with the impact of Gurnam, but as a young adult she lived with constant anxiety, worrying about her mother's safety.

7 Child to Parent Abuse (CPA)

'A slow and steady erosion of you as their mum…then suddenly they are in control.' Jo Sharpen[18]

7.1 Is CPA simply another form of interpersonal violence (IPV) that should be included in broader domestic abuse strategies?

1. This case, with the benefit of hindsight, furnishes a sobering 'worst case scenario', if, in agency support for families experiencing CPA, we fail to recognise the importance of early intervention and Early Help, of using a combination of approaches, and a 'Whole Family' methodology informed by a full family assessment.
2. It was the absence of that kind of holistic approach in this case that left a mother and daughter at continuing and escalating risk of abuse. Throughout the period under review, the family remained fatally fractured. This empowered a very young child to gradually take control of his family and maintain that grip throughout adolescence. For the whole period there was some awareness of the domestic abuse the family had fled, but very little professional curiosity to understand the impact on everyone in that family.
3. There was no appreciation of Jeera's emotional, psychological or financial resources. Deepika's needs, and the risk to her, were overlooked to a shocking extent. The lack of co-ordinated assessment and risk management meant that Gurnam became a domestic abuser as an adult, but the history of his childhood abusiveness seemed to have been forgotten or at least become irrelevant. Should Gurnam's child to parent abuse have been seen as a predictor of abuse as an adult?
4. This therefore leads to a reflective consideration of whether child to parent abuse is simply another form of domestic abuse? This seems problematic. Our professional instincts are that when a child is very young and demonstrating behavioural problems, we should be looking at early help to identify their needs, not finding ways of punishing or criminalising their behaviours. We would use a whole family approach, identifying the needs of each member of a family. We would seek to safeguard individuals from harm. Unlike adult abuse, where domestic violence protection orders and injunctions are removing the

[18] **Parent on a CPA Programme Helen Bonnick as below**

'perpetrator' and protecting the family, in the context of CPA, removing a child to become a LAC would probably be seen as a failure. A parent is legally responsible for their children up to sixteen. Even naming a young child as a 'perpetrator' would feel inappropriate.

5. Somewhere along the path from childhood to adolescence, children become accountable in society's eyes for their transgressions. In relation to CPA, though, would we want to criminalise a ten-year-old for domestic abuse? Given that the current definition of domestic abuse identifies sixteen as its starting point, then surely not. Yet the emphasis upon protecting 'victims' and our willingness to describe adolescents as 'young perpetrators'[19] appears to depend on the passing of years. Is it when young people can inflict the kind of injuries Jeera experienced from her teenage son, who was stronger than her and unrepentant? Is it when we need to formulate a 'safety plan'[20]? When an adolescent abuses a family member at fifteen, and a week later at sixteen, has he or she suddenly become 'just' a domestic abuser?
6. The current CPA guidance for Youth Justice places an emphasis on the possibilities of restorative justice; a solution that would be seen as inappropriate and dangerous with adult domestic abuse. There are therefore numerous distinctions between CPA and IPV.
7. In the context of this case, the long history of harm to Jeera and Deepika was tragic. The goal of all CPA work must surely be to safeguard each family member, to recognise all their needs and as far as possible meet them. In the same way that the tragic deaths of Jeera and Amrinder were the result of a failure to find a solution for the family, a child who remains abusive from childhood to adulthood must be seen as a failure of society.

7.2 Defining CPA

1. This DHR noted the terminology, '**Child to Parent Violence and Abuse'** (CPVA) preferred by the social worker, educator, and writer on CPVA, Helen Bonnick[21], who worked on the 2015 Home Office Information Guide: adolescent to parent violence and abuse (APVA).
2. Sandwell professionals involved in the Task & Finish group considering how to respond to the learning from this DHR have concluded that we should follow the terminology currently in the Home Office Draft Domestic Abuse Guidance 2021. This DHR therefore refers to Child to Parent Abuse (CPA) on the CLEAR understanding that abuse can be both physical as well as emotional.
3. The most helpful description of what CPA involves is that offered by Holt[22];

[19] **Information guide: adolescent to parent violence and abuse (APVA) section eight How to respond to APVA: Youth Justice**
[20] **Information guide: adolescent to parent violence and abuse (APVA) section eight How to respond to APVA: Youth Justice section 8.1**
[21] **Helen Bonnick 2019 Child to Parent Violence and Abuse A practitioner's Guide to Working with Families**
[22] **A. Holt (2015) Working with Adolescent Violence and Abuse towards parents Oxford Routledge**

"A pattern of behaviour, instigated by a child or young person, which involves using verbal, financial, physical and/or emotional means to practice power and exert control over a parent…The power that is practiced is, to some extent, intentional, and the control that is exerted over a parent is achieved through fear, such that a parent unhealthily adapts his/her behaviour to accommodate the child.'

4. The DHR acknowledged CPA was not properly identified until around 2010 to 2012, when first Wilcox[23] and then the University of Oxford[24] carried out studies of adolescent to parent violence. Our understanding of the nature of CPA is constantly evolving. This DHR provides an opportunity to look at practice in the period from 2003 to 2012 (when Gurnam was 18) and recognise what needs to change in agency responses to reduce the risk of a child developing a life-course pattern of abuse, because of a combination of possible mental health vulnerability, trauma, and family and environmental factors.

5. Studies have shown that 77% of all parent victims are female and of the young people using violence 87% are male. 66% involved son to mother violence.[25]

6. Early studies suggested that the peak age for CPA was 13-15 years old, but there is a growing belief that this may represent the age where most parents may feel they can no longer physically control their child. A study of CPA by Thorley and Coates (2018)[26] which asked parents when CPA began to be a problem found the highest prevalence to between 6 and 9 years old. Gurnam may have represented the norm, rather than an exception.

7. It is possible that whilst the challenges of adolescence (puberty, school transfers, peer relationships and influences) can lead to CPA becoming a problem at this age, it often recedes. Simmons[27] describes life-course persistent violence (starting earlier) as a factor to be considered.

c) Learning point: Professionals should be aware that CPA can start early in a child's life and become an entrenched problem

7.3 Early intervention and CPA

1. The opportunities to intervene early are therefore crucial with CPA - Holt.[28] At eight, Gurnam was already scaring peers, resorting to physical violence and threats and kicking and punching his mother, causing minor injuries. Helen Bonnick describes the escalating risk in these terms; '*very young children may be aggressive in their mood and behaviour, but they are far from doing the serious harm of a teenager. If*

[23] Wilcox. P (2012) is parent abuse a form of domestic violence? Social Policy and Society
[24] Funded by the Economic and Social Research Council
[25] Condry and Miles (2013) Adolescent to parent violence: framing and mapping a hidden problem
[26] Thorley and Coates (2018) Let's talk about child to parent violence and aggression CPA online
[27] Simmons et al (2018) Sixty years of child-to-parent violence what we know.
[28] A. Holt (2015) Working with Adolescent Violence and Abuse towards parents Oxford Routledge

we believe prevention or change is possible then the earlier that assessment, diagnosis and intervention can take place the better. All the evidence is that the severity of abuse is likely to increase over time, with the age and size of the child, and as patterns become fixed, potentially going forward into adulthood and future relationships.'

d) Learning point: Responses to CPA need to be commenced early to reduce the risk of escalation

2. Gurnam's teachers, CAMHS, all identified significant trauma as a probable cause of Gurnam's behaviours; witnessing his father's repeated domestic violence and intervening to protect his mother then being hit. The early referral of Gurnam was good practice. It was even more unfortunate, therefore, that eighteen months were 'wasted'. This was due to a combination of administrative errors but also a failure by teachers and Special Needs Co-ordinators to enquire early enough why treatment was delayed. There was quite early on evidence that Jeera would minimise the extent of harm her son was inflicting on her and her daughter.

7.4 A trauma-informed approach to CPA

1. Childhood trauma and post-traumatic stress disorder were clearly a plausible analysis in this family's experience. Safe Lives in their 2014 report, 'In Plain Sight', linked childhood experiences of domestic violence to the risk of then going on to use violence themselves. They looked at around 1200 cases drawn from four specialist services and found that children suffered multiple physical and mental health consequences because of exposure to domestic abuse. A quarter of the children were found to exhibit abusive behaviours themselves, mostly once their exposure had ended. Simmons' study noted that as many as 50% of children who had lived with interpersonal violence went on to use violence and abuse within the family. The counter argument, that this also means 50% of children so exposed do not use violence, does not, it is suggested, mean that a possible explanation for the prevalence of a behavioural problem in such a large cohort should be discounted.

e) Learning point: Children's experience of domestic abuse is a possible predictor for their later use of abuse within the family

2. The identification of the experience of domestic abuse appeared to lead to a shared professional perception that Gurnam's behaviours were 'expressive', that he probably could not control his reactions and that they were the result of trauma. It is worth remembering, however, that Psychologist 1 (section 4.2 paragraph 12) felt Gurnam showed signs of ADHD that he considered exploring, although this was never pursued. (There is a danger that because the signs of both are so similar, that there is an over diagnosis in one or other direction.)

3. If Gurnam's behaviours were 'expressive', then whilst his behaviours could not be excused, they could be explained. Professionals may have identified them as 'signs of distress'. He certainly exhibited impulsivity, often there appeared to be no trigger for his assaults or violence. Children who have experienced trauma and are violent are often diagnosed with conduct disorders; being unable to regulate and moderate their verbal, emotional and physical responses to the environment.

4. Best practice in CPA appears to suggest that the needs of each family member should be assessed, and whilst work can be done individually with the parents or child, the family need at some point to understand each other's perspective and perceptions and the reasons for their behaviours.

5. It is argued that too tight a focus on the child, to the exclusion of the parent, or vice versa, is likely to exacerbate the division between them, and increase the risk of blame attachment. If the conclusion was Gurnam was showing signs of distress, there seemed very little evidence offered of any positive one-to-one work to understand the causes of it. Gurnam disengaged at will, either during sessions or by refusing to attend. MH professionals considered the need for anger management in Gurnam's case, but then seemed to concentrate almost exclusively on Jeera's parenting.

6. Mental Health professionals were told about, and Gurnam consistently demonstrated, his obsession with knives and weapons, he justified and saw nothing wrong with his violent behaviours. He showed remarkably little empathy and as he grew older, no regret or contrition. He regularly expressed hatred and a desire to harm his father. Psychologist 3 was clearly worried about the level of violence Gurnam expressed and his '*serious intent'*. Yet after Psychiatrist 1 stated there was no mental health diagnosis, CAMHS proposed simply achieving 'behavioural change' with Gurnam yet no more direct work with him was carried out.

7. Gurnam chose not to engage with CAMHS sessions, but there did not appear to have been an attempt to understand why he was resistant. The DHR recognises that effective programmes with parents[29], helping them understand the causes of the behaviours, reducing their sense of shame and guilt can be hugely helpful, even where the child is refusing to engage, or resistant. It could be argued that parenting programmes can only be a partial solution. If Gurnam wouldn't engage, professionals should have examined why and identify whether they were offering the right kind of response, whilst recognising that a child could be in 'denial'. Deepika explained that Gurnam's mindset was contrary, he had in her view '*delusions of grandeur'* so he was unlikely to think that the opinions of Psychologists or his family were worth considering.

[29] **Who's in charge? Eddie Gallagher programmes in the UK Home Office Information Guide APVA**

f) Learning point: In relation to CPA, agencies should be wary of closing a case based on non-engagement

8. In Gurnam's case, the family appear never to have been given any real help to understand what was behind Gurnam's behaviours, because professionals (both mental health and Children's Services) never placed themselves in a strong situation to find out. The approach therefore became entirely focused on Jeera.

7.5 Avoiding blame in CPA

1. The emphasis of CAMHS Mental Health professionals appeared to be entirely upon addressing the perceived 'weaknesses' of Jeera's parenting, without understanding the whole family's perceptions. Jeera already saw herself to blame for Gurnam's behaviours and hoped that he would '*grow out of them'*. It is clear from talking to Deepika, that from her perspective, she believed that she and Gurnam had received very similar parenting from their mother and therefore she found Gurnam's responses unfair and unreasonable. (She did recognise that if trauma was the cause, Gurnam had probably seen more domestic abuse, because as young as she was, she remembered hiding when it occurred.) In her perception, Gurnam exclusively blamed Jeera and ignored the faults of his father. It does not seem that Gurnam can have expressed the hatred of his father, often expressed to professionals, in front of his sister. Deepika found her mother's willingness to give Gurnam '*another chance'* increasingly hard to accept, so that in later years, she was glad to be away from the home.

2. Helen Bonnick advances a political context for 'parent blaming', that reached a high-water point in the early 2000s. The Respect agenda advanced by the Labour Party from 1997 onwards focused on the family as the 'core of society' and had a 'zero tolerance' for neglectful parents. She argues[30] '*holding parents to account for their children's actions was a philosophy and movement which reached across the board, from anti-social and criminal behaviour on the streets, through educational commitment and attendance, to relationships in the home'.* Consequently, she concludes '*one thing you can be sure of is that parents have absorbed this way of thinking too, and their first response may well be to question how they have brought this on themselves. The general presumption is that children can be 'trained' through good parenting practices. Therefore, if I have a child who is clearly not 'trained' then it must be my fault'.*

3. The mental health professionals no doubt wanted to help the family and Jeera. However, the paternalistic attitudes of several male Psychologists seemed to suggest a lack of confidence that Jeera, a single mother, could cope. Her 'weaknesses' were addressed and dissected. She was offered rather patronising parenting tips. When Jeera sought support from friends; this was 'weak'. There is no

[30] **Helen Bonnick 2019 Child to Parent Violence and Abuse A Practitioner's Guide to Working with Families page 118-119**

indication from their notes that they recognised that as each year went by, Gurnam became more able to physically dominate Jeera and Deepika.

4. The part that Jeera and Deepika's fear of assault played in Jeera's responses was largely ignored. Had professionals shown more professional curiosity, they could have found out just how serious and debilitating the attacks were, as vividly described in the chronology. On numerous occasions, Jeera and Deepika would lock themselves in rooms, or Deepika would flee to a safe room as Jeera bore the brunt of Gurnam's attack. In later years, mother and daughter slept in a locked room with all the sharply pointed implements safely on their side of the locked door.

5. There is an irony that the improvements that Jeera so consistently reported to Psychologists were probably seen as a vindication of their parenting advice. Although they had once recognised a risk of '*denial*', they were prepared to close several periods of support without even seeing Gurnam. With hindsight, it seems far more likely that the victim blaming had heightened Jeera's sense of self-blame and shame. There is no substantial evidence that Gurnam improved in any way. His control apparently just became more comprehensive.

6. Within some CPA cases there will be incidents of poor or compromised parenting capability, a lack of clear boundaries, unrealistic expectations, or a refusal by parents to accept their share of responsibility. Parenting programmes may prove helpful. Shaming parents seems unlikely to ever be productive.

g) Learning point: In relation to CPA, professionals should avoid blaming language and recognise that there is a difference between shaming an adult or child and accountability for their actions.

7.6 Is intent relevant to understanding CPA?

1. Jeera and Gurnam were both clear that Gurnam also used threats, abuse and violence to overcome any boundaries set by his mother and intimidate her into submission. In this way he could stay up as late as he liked, go where he wanted, and do what he liked, without fear of challenge. This element raises an uncomfortable and controversial area in the discussion of CPA; intent. Sometimes called '*instrumental*' abuse, it feels uncomfortable, because expressive abuse seems more understandable, something that is largely out of a child's control. But if children set about their abuse with a plan, intending to coerce and control parents and by a pattern of abuse, threats, intimidation and violence achieve their aims, this seems harder to accept. It suddenly feels uncomfortably close to adult IPV.

2. In Gurnam's case, his abuse seems to have elements of unconscious expressive abuse and carefully formulated instrumental abuse. Yet it is probable that his lack of respect for women, his belief that a

violent response to his anger was neither a problem, nor one that he should be held to account for, were central to understanding the risk he posed to his family.

7.7 Assessing the whole family in CPA

1. The Assessment Framework (as expressed in the Sandwell Multi-Agency Threshold Matrix) is undoubtedly a useful starting point for the assessment of the family's needs. It takes the necessary holistic path, the child or young person's developmental needs, parenting capacity and family and environmental factors. Whilst social workers may be able to identify statements within the framework that properly apply to CPA, the Chair would argue that without some guidance, possibly in the form of an appendix, other professionals may find the matrix less helpful in describing the needs of the family.

   Recommendation: That the Sandwell Children's Safeguarding Partnership include a new annexe in the Sandwell Threshold Guidance document, that assists all professionals to understand, identify and assess the Early Help needs of the whole family in relation to CPA and promotes age-appropriate responses to child safeguarding.

h) Learning point: The Sandwell Threshold Matrix should be used as a starting point to assess and identify early help needs of all children affected by CPA, as well as the support provided and needed by parents.

7.8 Safety planning and CPA

2. At various points in the family's story, it would have been very helpful if professionals had understood more clearly their primary responsibility to safety plan with the Jeera. When Jeera described being assaulted by Gurnam as a child of 8 years old, the risk she faced were very different to those she faced confronting a fourteen or fifteen-year-old, who trained at the gym and sometimes came home drunk and very possibly under the influence of cocaine.

3. As Gurnam moved from primary to secondary school, there were contextual safeguarding issues. He now posed an escalating risk to himself and others and the little control Jeera was able to exert had almost completely been lost. Professionals were told of violent assaults on other children but did not initiate Child Protection referrals.

4. This is one of the challenges of building a positive relationship between a professional and a family; it cannot come at the expense of safeguarding and cannot be built on a foundation of unaccountability for the violent child or adolescent.

5. There was little evidence that any professional in that period, including Police, saw themselves as responsible for safety planning with a parent. It seems unlikely that this was because they were overly

focused on the needs or vulnerability of the child, rather that they thought it was the parent's responsibility to '*sort things out'*. It was striking, for example, that when Children's Services finally recognised the risk to Deepika and concluded they should safety plan, by accommodating Gurnam under section 20 (April 2010), they blamed the mother for failing to protect her daughter and told her she should press charges against Gurnam.

6. It seems extraordinary, with hindsight, that a former Looked After Child, accommodated because of the risk of harm he posed to his family, could move to live with the father who was largely responsible for the domestic abuse causing the PTSD that had been a central feature of his behavioural issues. Sandwell Children's Services would argue that they did not know and believed Gurnam was with his mother. This only illustrates the apparent absence of follow up with the family to ensure Jeera and Deepika were safe.

7.9 Whole Family approach in CPA

1. Each family's experience is different and unique. The assessment of need is a first step, not the end of the process. The range of responses professionals offer need to be empowering, not blaming. The current structures of child and adult safeguarding should not be allowed to push us towards using domestic abuse interpersonal violence responses and the criminal justice system. As parents struggle to impose boundaries and regain control, parenting advice and programmes become an important option. Where we recognise trauma and complex needs in a child, other direct therapeutic work could be required. Trauma-informed practice appears to be a key to successful work.

2. We may recognise wider family dysfunction in the context of the case, that may suggest the need for whole family work. The starting point from Helen Bonnick's perspective is '*parents acknowledging what is happening, to themselves and others including making it clear to the young person that this is not acceptable'*.

3. This case required professionals to identify the part that gender roles played in Gurnam's thinking. Deepika was emphatic that he had learnt to have contempt for women and would never accept rule and boundaries set by a woman. (Ironically, this was what persuaded Jeera that Jaswinder could provide a solution to Gurnam's attitudes although this may have said more about Jeera's own view of gender roles and her self-esteem)

4. Professionals working with a family should understand attachment theory; how and why was Gurnam both protective of his mother, angry with his father and abusive of them both? Gurnam had relied on the comfort of his mother's bed until he was 10 and as a young child would apologise to his mother for assaults and seek physical contact.

i) Learning point: identifying a support network is as vital in CPA as it is in domestic abuse and professionals should be alert to facts or changes that may affect the level or effectiveness of that support

5. The identification of a family's support networks is as vital in CPA as it is in IPV. Although the support of the Gurdwara could be said to have ended badly, with Gurnam responsible for an unprovoked assault upon two elders, Deepika was clear that in most respects, their involvement was very positive. They had provided a safe, 'listening ear' for Jeera. She felt able to share concerns that she was not able to talk about with her friends. Deepika was clear her brother was calmer, and they were all safer, when he was at the Gurdwara. Deepika was grateful that even after the violent incident, Jeera, who was deeply religious, was welcomed and supported.

6. There were a few other key people who provided Jeera support. Only Jeera's sister knew about the whole problem and, although supportive, she lived in India, so her support was largely of the moral kind. Jeera went to a holistic therapist for Gurnam; it was this friend who had contacted the NSPCC to express concern. Deepika pointed out that for a period their GP, a Punjabi speaker had been '*brilliant*' in supporting them all and '*went the extra mile'* to help. Unfortunately, he moved practice and this support was lost.

7.10 Embedding best practice in relation to CPA in Sandwell

1. The lack of awareness and recognition of CPA, during the period under review, was evident in a large part of the agency engagements with the family, described in the chronology of this DHR.

2. The need to provide local guidance to professionals that helps them develop a Whole Family approach to CPA is crucial. The Home Office Guidance provides a useful starting point, but local guidance should draw in both child and adult safeguarding considerations, as well as placing CPA in the context of intrafamilial domestic abuse.

   Recommendation: That the CPA Guidance currently being developed in Sandwell builds upon the current Home Office Guidance, by describing how Sandwell agencies should respond to CPA in a multi-disciplinary and holistic way, recognising both child and adult safeguarding, as well as the importance of a 'Whole Family' approach to assessing that family's needs and wishes concerning CPA. The guidance should recognise that appropriate responses would take into full account the vulnerabilities of both the child and the adult and should be regularly reviewed where risks remain, as a child moves into adolescence or becomes a young adult.

3. The Richmond Fellowship have recently received Home Office Perpetrator Programme Fund and Office of the Police and Crime Commissioner match funding to develop with Women's Aid, a Black Country-

wide programme of support for young people using violence and abuse. This has the potential to provide a valuable local support service as part of a holistic approach to CPA.

4. The DHR recognised that in 2021, understanding of CPA has progressed and that the response of Children's Services (including YOTs), Police services and the National Probation Service would be informed by the Home Office Guidance and changes to agency best practice.

5. It was felt by the DHR, however, that there remains work to be done in Sandwell helping professionals to assess the needs of the whole family experiencing CPA. To this end it was felt that multi-agency training using this DHR as the basis for a case study, could be helpful in achieving better responses to CPA.

   Recommendation: That a multi-agency case study-based training package on CPA be created that could be delivered to frontline professionals, having as its objectives to increase understanding of CPA and awareness of best practice in line with the new Sandwell Guidance on CPA

6. In 2022, the NHS Black Country Integrated Care Board (ICB) sponsored a podcast that assists both primary care and other professionals to understand a family's perspective on the support offered in response to CPA, as well as best practice based on research. Deepika offered moving insights relating to her experiences. The DHR Chair obtained the participation of Dr Amanda Holt from the University of Roehampton, who was the author of the first book on CPA[31] and has conducted the only UK research on parricide. Also involved was Dr Victoria Baker, who carried out the first comprehensive review of research on CAPVA on behalf of the Domestic Abuse Commissioner[32]. To assist practitioners to understand how to respond to CPA, Justine Dodd from Respect, who has experience of working with frontline professionals dealing with CAPVA and a senior Social Work manager from Sandwell Children's Trust, Kate Mullinder, participated in the podcast. The podcast is hoped to be made available for general circulation.

8 Intrafamilial Domestic Abuse and domestic homicides

1. During conversation with the DHR panel, Deepika noted that at no point did professionals characterise her brother's abuse as domestic abuse. This may be in part because it was abuse that changed in nature, severity and significance, as the abuser went through the stages of life. The detrimental impact on the family's wellbeing and the harm to the victims stayed a constant.

[31] **Dr Amanda Holt: Adolescent to Parent Abuse Current Understandings in Research, Policy and Practice**
[32] **Dr Victoria Baker, Helen Bonnick - Understanding CAPVA: A Rapid review of the Literature on Child and Adolescent to Parent Violence and Abuse**

2. This DHR has attempted to place the events in context with changing and current DA definitions (children witnessing domestic abuse are now recognised as victims in the new statutory definition of DA) but also our evolving understanding of CPA.

3. The DHR has attempted to describe the different approaches and decisions required in addressing CPA during the transition of a child into adolescence. What weight, for example, did this history have in decisions around prosecution of Gurnam? It is far from clear whether a history of CPA would be seen as a consideration in a decision whether to prosecute an adult abusing a parent. However, he had been convicted and cautioned for offences against his family in Northamptonshire, as an adult. An identification of the family circumstances and history should have given officers pause for thought. The last assault reported by Jeera to WMP was in 2017 and was apparently not considered for an evidence-led prosecution. It is very likely that the known history was not considered relevant in any decision-making, particularly given Jeera's insistence that she did not want to proceed.

4. Gurnam had been arrested three times as an adolescent for assault on his mother, but never charged or cautioned for offences against her. This DHR has identified a life-course history of assaults on his mother by Gurnam. It could be argued that a history of assault spanning sixteen years could be considered a compelling sign of risk. It seems important that professionals recognise the life-course nature of CPA and avoid minimising its significance in later years, in cases where a parent is still being victimised by an adult child.

j) Learning point: where an adult parent is a victim of domestic abuse by their adult child, Police should be professionally curious and consider the possibility of CPA and seek details of history to identify the early onset of abusive behaviours in the offender.

5. This DHR would hesitate to draw firm conclusions on the risk to Jeera and Amrinder, that could be drawn from the history. The research around parricide is very limited. However, in a 2016 study of available literature[33] Holt and Schon noted the concentration upon adolescent offenders. A study in 2004 by Cotterell and Monk, based on psychoanalytical notions of retribution, suggested that '*anger and resentment about past abuses are either targeted toward the figure who enacted the abuse or displaced onto the (often also-abused) parental figure who "allowed it to happen"'.*

6. Theories regarding adult-perpetrated violence towards parents are, apparently, almost non-existent. However, Holt postulates we should examine the developmental pathway into violence against parents. This should be accompanied by a consideration not only of a subject's stage in the life course, but also

[33] **Holt and Schon Exploring Fatal and Non-fatal Violence against Parents Challenging the orthodoxy of abused adolescent perpetrators**

tracking changes over time. This would include identification of early onset violence as opposed to its development in adolescence. The developmental pathways Holt identifies seem resonant in this case '*mental illness, developmental disorders, witnessing domestic violence, poor attachment patterns and family stress*'.

7. CPA is a distinct and complex form of abuse, but this DHR has shown that it can have the same outcomes as all other forms of IPV.

9 Supporting families to access Mental Health Services

9.1 Childhood mental health support

1. Deepika expressed frustration and disappointment to the DHR panel with the responses of Mental Health Services over the years, as her mother tried to get support for Gurnam's mental health. In section six and seven we have considered the impact of trauma on Gurnam's mental health and, importantly, identified a child's latent vulnerability to mental health problems, related to the changes to the brain caused by exposure to neglect or abuse. The DHR has described response that were 'of their time', showing a lack of awareness of childhood developmental trauma.

2. It is unproductive to question the assessments of Psychologists and Psychiatrists, that Gurnam had no diagnosable mental health condition, even if the family felt he had, although the '*potential to develop psychosis*' left the door open for later assessment. It also leads to the question, if psychosis was possible, were there no preventive treatments suitable for adolescents, such as counselling or medication?

3. As has been the case throughout this DHR, relevant national guidance and policy seemed to always be a few years too late. Guidance in all areas of mental health is usually a consolidation of current practice, or a re-emphasis on one area over another, based on empirical evidence.

4. The relevant NICE guidance[34] advised '*when transient or attenuated psychotic symptoms or other mental state changes associated with distress, impairment or help-seeking behaviour are not sufficient for a diagnosis of psychosis or schizophrenia: consider individual cognitive behavioural therapy (CBT) with or without family intervention'.*

[34] **NICE Guidance 155 (2013) Psychosis and Schizophrenia in Children and Young People: Recognition and Management. Clinical Guideline 155. NICE, 2013 (http://guidance.nice.org.uk/CG155).**

5. The DHR would suggest that this was a potential pathway for Gurnam, that should have been available in 2010. The indications from the chronology and his sister's reflections are that Gurnam may have refused to engage, because he was in denial of developing mental health problems. This pattern was consistent when Gurnam was an adult. The DHR considered the minimising of concerns by Gurnam's mother. The BCPFT IMR contains multiple examples between 2003 and 2010 of Jeera apparently underplaying the nature of Gurnam's problems. This may have been for totally understandable reasons, but it threw treatment off course. If, for example, Jeera had expressed concern when Gurnam was discharged from EIT in June 2010, it is probable the LAC CPN would have re-doubled her efforts to speak to Gurnam, rather than contenting herself with a second-hand report from Jeera.

6. Although it seems slightly contradictory, it is not surprising that in her dealings with Northampton Children's Services, after Gurnam had assaulted his father, Jeera was still pressing for CAMHS involvement. It seems she needed in her mind a diagnosis of a mental health problem relating to Gurnam. In relation to victims of CPA, families are often desperate for an explanation of the abusive behaviours, to lift some of the sense of self-blame. This seems a totally understandable reaction and does not alter the fact that, throughout this case, Jeera wanted to help her son.

9.2 Supporting families to access mental health services for adult family members

1. There is no doubt that in her discussion with the DHR panel, Deepika felt the strongest frustration with the period she, her mother and stepfather Amrinder spent in late 2019, trying to obtain a mental health assessment for her brother.

2. Deepika's testimony was vivid and clear. The family was sure that Gurnam was mentally ill. He would speak '*gibberish'* and seemed to be holding conversation with people, '*over your shoulder'*. He lived in a state of paranoia; at family home 1 he had kept a baseball bat and knife by the front door. He had no regard or respect for others and what Deepika described as '*delusions of grandeur'* (sometimes linked to bipolar disorder and schizophrenia). He was sleeping poorly. At various times he made clear his intention to kill Jeera and Deepika, talking about using knives and machetes. His history of fascination with and possession of knives and the advantage of hindsight makes this seem a chilling reality. Deepika said that she was fearful for her mother and her, whilst Jeera, who always thought the best of Gurnam, was apparently more worried for Gurnam himself and others. (Both situations could trigger an application under the Mental Health Act section 2 if Gurnam had a diagnosable mental disorder).

3. Gurnam however had no desire for mental health support; he had absolutely no insight into his behaviours and was apparently in complete denial that he had any mental ill-health. It was possible evidence of condition known as anosognosia. It is common in cases of schizophrenia (present in 30% of cases) a study concluded[35]: '*Poor insight is a cardinal symptom of schizophrenia that, while not universally and uniformly expressed in all patients, is among the most common of its manifestations'* This poses challenges for families seeking support for an adult in denial. National Institute for Clinical Excellence (NICE) guidance 178 (2014) for Psychosis and Schizophrenia in Adults: Treatment and Management places a heavy emphasis upon cognitive-behavioural therapy over medication (or a combination of both). In an article in The British Journal of Psychiatry, Taylor and Pereira[36] note, 'NICE Guidance *CG178 seems oblivious to the fact that many patients with acute schizophrenia have impaired insight into their illness and mental health needs and thus may not have capacity to consent to the treatments.*'

k) Learning point: it is important that mental health professionals and GPs are reminded of the link between anosognosia and schizophrenia, when identifying a patient's apparent lack of insight into their mental health condition.

4. The family did what they could to offer support. They discussed concerns with Gurnam's GP. Deepika said Gurnam's GP apparently felt that '*there was something wrong'* with Gurnam. The GP listened to Jeera and Deepika's concerns and provided phone numbers to contact, to obtain a mental health assessment. It is not clear whether he suggested Gurnam book a review at the surgery and Deepika cannot recollect whether this was suggested, but in a patient seeking help for signs of schizophrenia this would have been the path into mental health services. Gurnam had had no contact with secondary Mental Health services and a review in primary care would be usual.
5. The GP's immediate advice was to take Gurnam to an ED department and seek an assessment and this suggests he took it that Gurnam was in urgent need of care. It should be noted that he had not seen Gurnam in the immediate lead up to the events described below and therefore was giving his advice based on the family's assessment.
6. The chronology describes how Gurnam was taken to the QE ED using a contrived pretext; Jeera was receiving results from a previous 'consultation'. With hindsight, this was very unlikely to be helpful. Gurnam had probably been anxious, felt tricked and angry and was entirely uncooperative, and it is

[35] **Lehrer and Lorenz: anosognosia in schizophrenia: hidden in plain sight.**
[36] **Taylor and Pereira NICE CG 178 Psychosis and schizophrenia in Adults - an evidence based guideline?**

not entirely surprising that the triage nurse reacted by admonishing the family for this deceit. However, in defence of Jeera and Amrinder and Deepika, they were now desperate for help and were unaware of any right to seek a mental health assessment for Gurnam in the home. (see below) Ironically, Deepika, in her conversation with the DHR panel felt that their best hope of persuading Gurnam to engage with an assessment would have been a planned assessment in a safe space, like the family home.

7. Where an adult is compliant and apparently consents to a mental health assessment, this path seems entirely sensible. However, Gurnam was not compliant nor was he apparently presenting as 'in crisis', on a short observation. Deepika explained that for 10 minutes or so, Gurnam could appear plausible and 'fine'. After a longer conversation, she felt his mental health issues became more obvious. Since he was not seeking assessment, the triage nurse did not have the opportunity, or need, to have a longer conversation.

8. Gurnam had not presented with any physical health conditions requiring assessment, nor was he apparently presenting as in crisis from a mental health perspective; he did not show signs that he had a mental illness requiring immediate 'care and control' of the kind that would prompt a section 135 application for detention or a detention by a police constable under section 136 (a power that could be used by police in ED if required).

9. The triage nurse had had no mental health training beyond modules on initial training. The nurse did, however, correctly check out decision making with a senior nurse, doctor and consultant. What is unclear is whether the nurse shared all relevant information in the discussions with colleagues.

10. There is a lack of clarity and agreement as to how detailed a description of Gurnam's condition and history the family gave to ED staff. Most crucially, the 'risk of harm' to others appeared not to have been explored by ED staff.

11. The hospital's records suggest Gurnam was reported as; '*acting strangely and taking, zopiclone, propranolol and amitriptyline'*. (These were all medications prescribed by Gurnam's GP). The family's description of the threats of serious harm made by Gurnam should have raised concern, but the triage nurse recorded that '*he did not pose a threat to himself or others'*.

12. In her discussion with the panel, Deepika was categorical that they had described the detailed nature of Gurnam's threats to harm them but had been told by the triage nurse this should be reported to Police. This suggests they were not taken properly into account and appears to have represented a triage error.

There was no reason to doubt Gurnam's mental capacity; Gurnam was apparently clear in his refusal of an assessment by psychiatric liaison services and did not give the nurse any reason to doubt capacity. (Had there been prompts on the system in relation to MCA, they could have included absence of self-awareness of a mental health condition in psychosis). Had there been any doubt at all, then a properly recorded capacity assessment, showing how the decision on capacity had been reached, would be required by the hospital.

13. Since this presentation, a new process of triage has been introduced based upon the "Manchester Triage Tool". Staff are expected to be within ED for six months before they start training and must be signed off as competent before triaging independently. A more detailed mental capacity prompt is being included in new triage systems being developed, which highlights the need to assess capacity in relation to mental health assessments.

14. Even if Gurnam had been considered to lack capacity, but refused to remain to be assessed, the Mental Capacity Act did not give the triage nurse powers to detain Gurnam. This could only be achieved using the Mental Health Act (MHA) if a doctor believed Gurnam was suffering from a mental disorder and detention was necessary for emergency assessment. It could be argued that the threat of harm to others should have triggered such an assessment.

15. Section 4 of the MHA allows that clinician, together with either an Approved Mental Health Professional (AMHP) (or on very rare occasions, a nearest relative), to seek emergency admission of a patient for up to 72 hours. This allows sufficient time for a second clinician to assess whether detention under MHA section 2 is required (Up to 28 days). Section 4 is not used routinely, since the assessment and agreement of two clinicians is clearly safer, less restrictive and preferable. There was little evidence provided to the DHR from any source to suggest that Gurnam presented on this occasion in an acute mental health crisis.

16. However, if Gurnam was suffering mental ill health and psychosis, and was posing a risk of harm to others, it could be argued that ED should have sought an urgent mental health assessment.

17. Frustrated in their attempt to obtain a mental health assessment in ED, the family called ASSIST, the call handlers to allow the public to access Adult Social Care. The advice they were given (section 4.7 paragraph 25) made no mention of 'nearest relative' rights.

18. In July 2021, the DHR Chair discussed the Sandwell ASSIST response with the Adult Social Care Divisional Managers responsible for AMHPs in Sandwell and Birmingham. Whilst Birmingham was not directly involved with the family in relation to accessing 13(4) MHA nearest relative rights, both managers

undertook to review their local provision and pathways, to ensure that they were accurate and clear, and that online advice reflected best practice and included appropriate safeguarding advice.

19. Deepika stated that in the months before the homicide, Jeera reported 'some improvement' in Gurnam's mental health. It is hard to be sure how reliable this was, since Jeera tended to try and shield her daughter from the true threat levels.

Recommendation: That the Black Country Healthcare NHS Foundation Trust (BCHFT) should review existing pathways into the Trust's mental health support and update them where necessary, and promote those pathways with the Black Country & West Birmingham Clinical Commissioning Groups and all Hospital Trusts referring into BCHFT:

- **The pathways should facilitate professionals in Primary Care teams and Hospital Trusts with Emergency Departments to make appropriate and timely referrals into the Trust Mental Health services.**
- **It should enable those same professionals to correctly advise families when and if they can access mental health support for a family member who has capacity, where that person is either compliant or non-compliant.**
- **It should identify how professionals and families (including 'nearest relatives') should access emergency assessment and potentially treatment, where they believe that family member to have a mental disorder of such a nature and degree that they are at risk of harm to themselves or others.**
- **The pathways should also clearly identify to the public when and if self-referral into Trust services, or referral into mental health services on behalf of a family members, are appropriate.**

l) Learning point: GPs and other professionals should be aware of the right under section 13(4) for the nearest relative to request that an AMHP assess their relative.

20. A 'nearest relative' in this instance a mother, could ask social services for a mental health assessment. It is a crisis response and can be requested in writing, or verbally. The request could also have been made by the GP or Deepika, on the nearest relative's behalf. The nearest relative would need to explain the behaviours causing concern and why they consider the person may be a risk to himself or others.

21. The AMHP then must 'consider the case' and if they decide not to assess the patient, the nearest relative must be informed why not. If a GP has made a referral through to the CRISIS team, then an AMHP may

conclude an assessment is not necessary. Or if the Community Mental Health Team are already working with the patient and do not feel a mental health assessment is necessary.

22. This route may have been helpful in this case and it is a pathway about which professionals should have a better appreciation. It remains a matter of conjecture whether Gurnam would have presented to an AMPH as in crisis, requiring hospitalisation, however it may have allowed the family access to mental health support.

Recommendation: The Sandwell and West Birmingham Clinical Commissioning Group, Sandwell and West Birmingham Hospital Trust and University Hospitals Birmingham NHS Foundation Trust should ensure that their practitioners are aware of the scope and application of section 13(4) of the Mental Health Act and are aware and can advise in relation to when it may be appropriate for the 'nearest relative' seek an assessment from a Local Authority Approved Mental Health Professional (AMHP). The advice should complement current guidance to primary and secondary care in relation to seeking access to mental health support for patients.

Recommendation: Sandwell Metropolitan Borough Council Adult Social Care and Birmingham City Council Adult Social Care should ensure and provide assurances that pathways and online guidance to section 13(4) MHA 'nearest relative' assessments requests are clear and accurate, properly publicised and understood by call handlers receiving requests for such support as well as those managing and providing this service within Adult Social Care.

23. In 2022 the NHS Black Country Integrated Care Board (ICB) sponsored a podcast to assist primary care and other professionals to respond more effectively to families seeking mental health support for a loved one. Deepika agreed to be involved and explained her family's experiences as outlined in the DHR. Julian Hendy from 100 Families participated to offer a national perspective, and local guidance and support was described by Dr Min Hundle, the Named GP for Sandwell and Julie Price, Head of Adult Safeguarding for the BCHFT. The podcast is hoped to be made available for general circulation.

24. Deepika explained that after the visit to the QE ED, Gurnam presented in similar ways, still causing anxiety to her and Amrinder and Jeera, but presumably not in so severe a presentation that they needed to call 999 to require emergency responders.

25. After his arrest for the homicide of his mother and stepfather, Gurnam was assessed in police custody by a Liaison and Diversion CPN as 'fit to be detained' and 'fit to be interviewed'. This would suggest that Gurnam was not showing signs of mental disorder. Deepika believed, from conversations with the Family

Liaison Officer, that investigating officers did detect signs that led them to two further assessments whilst in custody.

26. Gurnam did not advance a defence of diminished responsibility at his trial and the DHR has not seen any mental health assessment conducted by the defence. It is not possible therefore to state whether Gurnam was suffering any metal health crisis at the time of the homicides.

10 Conclusions

1. The DHR was enhanced by the perceptive and constructive observations of Deepika, who spent most of her childhood and early adult life supporting her mother, Jeera, to find appropriate responses to her brother's behaviours, as her mother tried her best to keep them all safe and achieve positive change. Tragically, the family were seeking support from professionals at a time where there was a lack of awareness of ACEs, and where practice was rarely fully trauma informed.

2. Although Child to Parent Abuse was beginning to be recognised and described, understanding of it was not widespread, even across agencies that would be expected to deal with its affects. Consequently, there was limited evidence of the 'Whole Family' approach that should be taken in 2021. The DHR's recommendations aim to ensure that Sandwell adopts best practice in relation to this complex area.

3. It is not surprising, though, given Gurnam's behaviours, that Jeera and Deepika were persuaded from an early point that the root cause was Gurnam's undiagnosed mental health problem. That mental health professionals did not explore with them in a methodical way their assessment of Gurnam as a child, or the impact of ACEs or link behaviours to trauma, meant that the family persisted into Gurnam's adulthood in seeing mental health support as the only viable solution to Gurnam's issues. The learning from this DHR would suggest that Early Help in its broadest sense, including working with the family to understand their shared trauma, may have prevented the steady and relentless collapse of the family and the deterioration in Gurnam's mental health.

4. What is clear from this sad case is that probably only early interventions involving the whole family, supported by all relevant agencies, can prevent CPA becoming entrenched to the extent that a perpetrator poses a threat of interpersonal violence into adulthood.

5. The clear, explicit threats of violence so often made by Gurnam to his mother and sister never assumed the prominence that, with hindsight, they should have. In part this was because Jeera believed until the end her son could change, and therefore was reluctant to report these chilling threats to the Police.

6. That Gurnam was never formally assessed by mental health professionals in adulthood and was not referred to mental health services by his GP or ED staff because he was unwilling to engage, meant the family's concerns went unaddressed. They felt in the months before the homicide that he was exhibiting elements of psychosis and was a danger to them and others. The unsuccessful request to obtain such an assessment in ED failed because of a combination of an apparent lack of 'florid' mental health symptoms, an ill-conceived plan to get Gurnam to the hospital and a triage process undertaken by a nurse with insufficient training in mental health and a lack of experience.
7. The lack of awareness of pathways to Mental Health support meant the family were given only limited guidance on the rights of a nearest relative to seek an AMHP assessment. The DHR will never know what the outcome of such an assessment in the last months of Jeera and Amrinder's life would have concluded. It is possible that he would have been identified as suffering a mental health crisis requiring emergency assessment and hospitalisation.

11 Recommendations

The Domestic Homicide Review recommends that:

1/That the Sandwell Children's Safeguarding Partnership include a new annexe in the Sandwell Threshold Guidance document, that assists all professionals to understand, identify and assess the Early Help needs of the whole family in relation to CPA and promotes age-appropriate responses to child safeguarding.

2/That the CPA Guidance currently being developed in Sandwell builds upon the current Home Office Guidance, by describing how Sandwell agencies should respond to CPA in a multi-disciplinary and holistic way, recognising both child and adult safeguarding, as well as the importance of a 'Whole Family' approach to assessing that family's needs and wishes concerning CPA. The guidance should recognise that appropriate responses would take into full account the vulnerabilities of both the child and the adult and should be regularly reviewed where risks remain, as a child moves into adolescence or becomes a young adult.

3/That a multi-agency case study-based training package on CPA be created that could be delivered to frontline professionals, having as its objectives to increase understanding of CPA and awareness of best practice in line with the new Sandwell Guidance on CPA.

4/ That the Black Country Healthcare NHS Foundation Trust (BCHFT) should review existing pathways into the Trust's mental health support and update them where necessary, and promote those pathways

with the Black Country & West Birmingham Clinical Commissioning Groups and all Hospital Trusts referring into BCHFT:

- **The pathways should facilitate professionals in Primary Care teams and Hospital Trusts with Emergency Departments, to make appropriate and timely referrals into the Trust Mental Health services.**
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- **The pathways should also clearly identify to the public when and if self-referral into Trust services, or referral into mental health services on behalf of a family members, are appropriate.**

5/The Sandwell and West Birmingham Clinical Commissioning Group, Sandwell and West Birmingham Hospital Trust and University Hospitals Birmingham NHS Foundation Trust should ensure that their practitioners are aware of the scope and application of section 13(4) of the Mental Health Act and are aware and can advise in relation to when it may be appropriate for the 'nearest relative' seek an assessment from a Local Authority AMHP. The advice should complement current guidance to primary and secondary care in relation to seeking access to mental health support for patients.

6/ Sandwell Metropolitan Borough Council Adult Social Care and Birmingham City Council Adult Social Care should ensure and provide assurances that pathways and online guidance to section 13(4) MHA 'nearest relative' assessments requests are clear and accurate, properly publicised and understood by call handlers receiving requests for such support as well as those managing and providing this service within Adult Social Care.