Civic Offices
Merrial Street
Newcastle-under-Lyme
Staffordshire
ST5 2AG

OVERVIEW REPORT

DOMESTIC HOMICIDE REVIEW

in respect of

D

Born 1948

Chris Few
December 2015

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INTRODUCTION

1.1 Domestic Homicide Reviews were introduced by the Domestic Violence, Crime and Victims Act (2004), section 9.

1.2 A duty on a relevant Community Safety Partnership to undertake Domestic Homicide Reviews was implemented by the Home Office through statutory guidance in April 2011. The 'Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews' was updated in August 2013 and that revision provided the framework within which this Review was conducted[1].

1.3 A Domestic Homicide Review (DHR) is defined[2] as:

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 was related or with whom he was or had been in an intimate personal relationship, or
- a member of the same household as himself,

held with a view to identifying the lessons to be learnt from the death.

1.4 The purpose of a DHR is to:

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

1.5 DHRs are not inquiries into how the victim died or into who is culpable; that is a matter for Coroners and criminal courts. They are also not specifically part of any disciplinary enquiry or process; or part of the process for managing operational responses to the safeguarding or other needs of individuals. These are the responsibility of agencies working within existing policies and procedural frameworks.

[1] www.homeoffice.gov.uk.
[2] Domestic Violence, Crime and Victims Act (2004), section 9 (1).

2 Summary of Circumstances Leading to the Review

2.1 The victim (D) and perpetrator (G) were father and son respectively. G lived with his mother (Z) and D in Staffordshire.

2.2 In October 2014 Police attended the family's home address at the request of D's wife who had received a telephone call from D which raised concern that G would harm him. D was found with severe stab wounds to his head and neck and despite the efforts of paramedics he died at the scene a short time later.

2.3 G was arrested at the scene and subsequently charged with the murder of D.

2.4 On 13 November 2014 a Scoping Panel convened on behalf of the Newcastle-under-Lyme Community Safety Partnership considered the circumstances of the case and concluded that the criteria for conducting a Domestic Homicide Review were met. A recommendation to commission a Domestic Homicide Review was endorsed by the Chair of the Community Safety Partnership who was present at the meeting.

2.5 In September 2015 Stafford Crown Court accepted medical advice that G was suffering from paranoid schizophrenia and unfit to stand trial. A hearing of the facts was however held and the jury decided that G had unlawfully killed D. G was ordered to be detained in a secure hospital.

3 Terms of Reference

3.1 The full Terms of Reference for this Review are at Appendix A. The following is a summary of the key points.

3.2 The Review considered in detail the period from 5 May 2006 when G was involved in a serious road traffic collision, to the date of D's death. Summary information regarding significant events outside of this period and in particular concerning the service of D and G with the British Army was also considered.

3.3 The focus of the Review was on the following individuals:

Name	D	G
Relationship	Victim	Perpetrator
Age	66	43
Gender	Male	Male
Ethnicity	White British	White British

3.4 The only other member of the immediate family is Z, wife of D and mother of G.

3.5 In addition to the general areas for consideration outlined in the statutory guidance the Review specifically considered:

- The mental health of D and the effectiveness of services to address any needs, including those of any informal carer, associated with this

- The mental health of G and the effectiveness of services to address any needs, including those of any informal carer, associated with this

- The potential impact that involvement with the British Army of D and / or G may have had on events leading to D's death.

4 Review Panel Chair and Independent Overview Report Author

4.1 The Review Panel was chaired and this report of the Review was written by Chris Few, an Independent Consultant. Mr Few has chaired review panels and written overview reports on behalf of numerous Community Safety Partnerships, Local Safeguarding Children Boards and Local Authorities in connection with Domestic Homicide Reviews and Serious Case Reviews[3]. He has no professional connection with any of the agencies and professionals involved in the events considered by this Review.

5 Review Panel Members

5.1 The Review Panel comprised the following post holders:

- Personal Support Officer
  Army Welfare Service

- Community Safety Officer - Domestic Violence Lead
  Newcastle-under-Lyme Borough Council

- Lead Nurse Adult Safeguarding
  North Staffordshire and Stoke-on-Trent Clinical Commissioning Groups
  (On behalf of NHS England)

- Trust Safeguarding Lead
  North Staffordshire Combined Healthcare NHS Trust

- Principal Community Safety Officer
  Staffordshire County Council

- Senior Investigating Officer
  Staffordshire Police

- Crime and Policy Review Manager
  Investigative Services Policy, review and Development Unit
  Staffordshire Police

- Adult Safeguarding Nurse
  University Hospitals of North Midlands NHS Trust).

[3] Under the Children Act (2004) and its associated statutory guidance.

6 Review Process

6.1 The Review Panel met on 9 February 2015 to consider contributions to and emerging findings of the Review:

6.2 This Overview Report was completed following conclusion of the associated criminal proceedings in order that the contribution of S could be included, which meant that the Review took longer than the six months recommended in the statutory guidance. The Report was endorsed by the Review Panel on 10 December 2015 and forwarded to the Chair of the Newcastle-under-Lyme Community Safety Partnership. It was subsequently presented to and endorsed by the Community Safety Partnership.

7 Contributions to the Review

7.1 Requests to confirm the extent of their involvement with the subjects of this Review were sent to all statutory and voluntary agencies in Stoke-on-Trent and Staffordshire who may potentially have had such involvement. This scoping process was used as the basis for more targeted requests for Management Review and Summary Information Reports.

7.2 Management Review and Summary Information Reports were submitted by:

- East Cheshire NHS Trust
- NHS England (Primary Care Services)
- Newcastle-under-Lyme Borough Council
- North Staffordshire Combined Healthcare NHS Trust
- Staffordshire Police (including details of British Army service)
- University Hospitals of North Midlands NHS Trust
- West Midlands Ambulance Service NHS Trust.

7.3 Other sources of information accessed to inform the Review included:

- British Army records in respect of D
- British Army records in respect of G.

8 Parallel Processes

8.1 The criminal investigation into the killing of D was conducted in parallel with this Review.

8.2 HM Coroner for Stoke-on-Trent and North Staffordshire opened and adjourned an inquest pending the outcome of the criminal investigation. Consequent to the judgement at Stafford Crown Court that G unlawfully killed D HM Coroner decided that there was no useful purpose in resuming the inquest into his death.

8.3 North Staffordshire Combined Healthcare NHS Trust commenced a Serious Incident Investigation in relation to their involvement with G. That process was put on hold once this Review was commissioned and shortly afterwards the Trust's commissioners agreed that in line with the national SI framework there would not be a need for a Serious Incident Investigation as G's contact with the Trust was outside the timeframe that would usually require an investigation.

9 Family Engagement

9.1 D's wife (Z) was advised of the Review at its outset. Following the conclusion of criminal proceedings she and her Police Family Liaison Officer met with the Review Panel Chair on 25 November 2015. Information and views provided during that meeting have been incorporated into this report and the Chair is grateful for this valuable contribution.

9.2 G was also informed of the Review at its outset. No response was received from him.

9.3 Z was given sight of this report on completion and prior to its submission to the Home Office.

THE FACTS

10 Background of the victim and perpetrator

10.1 **D**

10.2 D (aged 18) joined the Territorial Army (TA) in 1966. He intended to serve in the Parachute Regiment for 4 years but left in 1968. The reason for him deciding to leave early is unknown.

10.3 In 1970 D (aged 22) applied to join the King's Division of the regular Army and was accepted. At that time he was recorded as being married with a child expected. His wife accepted that there would be no entitlement to married quarters during D's basic training.

10.4 During D's basic training he was absent without leave on two occasions and then bought himself out of the Army citing domestic reasons. Z informed the Review that this concerned problems that she was experiencing with a particular neighbouring family whilst she was living alone.

10.5 In 1973 D re-joined the King's Division of the Army and it was recorded that the domestic reasons for him leaving previously had been resolved. He thereafter remained in the King's Division until discharged in 1985 (aged 37).The majority of D's time within the Army was as an arms storeman or in administrative roles although it included two operational tours to Northern Ireland in 1975 and 1979.

10.6 During the 1979 tour D was based in Belfast where he was employed as an escort in the Royal Military Police (RMP) Pointer Team[4]. There is no record of D being exposed to any specific incident which may have led to him suffering from PTSD. It was however noted at the end of the tour that D "works very hard and is a cheerful soldier but is understandably best employed in an administrative job". There is no information to clarify what was behind this assessment but it may be speculated that this was to keep him away from front line duties consequent to some event during the tour[5].

10.7 When D left the Army his testimonial stated that his conduct had been exemplary.

10.8 Z informed the homicide investigation that during his military service he had seen some "pretty awful things" which had affected him later in life; he suffered Post Traumatic Stress Disorder (PTSD) and was no longer able to work because of this.

[4] In 1979 the role of a Pointer Team included visiting the scenes of explosions and shootings to secure the scene for investigation and assist in the handling and documentation of recovered weapons.

[5] During the 4 month 1979 tour three soldiers of the King's Division were killed. Kingsman Shanley and Lance Corporal Rumble were killed in the same vehicle by a PIRA sniper, while Lance Corporal Webster was killed by a remote-controlled bomb.

10.9 In September 1991 D was seen by his GP for anxiety with depression and recorded as having Post Traumatic Stress Disorder. He received Cognitive Behavioural Therapy for this but continued to suffer from recurrent depression and continued to periodically see his GP, being prescribed anti-depressant medication. In 1996 he was recorded as suffering from "morbid jealousy" although this was not further explained and its context is not known.

10.10 Prescription of anti-depressant medication to D by his GP continued throughout the period under review.

10.11 **G**

10.12 Z told the Police that ever since G was a child he wanted to be in the Army and had applied to join the regular Army but could not get in because he had asthma.

10.13 G joined the Territorial Army in 1989 (aged 18) and was stationed at the Royal Army Medical Corps, 207 Field Hospital, Manchester. His role was that of a combat medical technician.

10.14 G carried out basic combat training with the regiment. This involved him being taught how to fire, strip down and reassemble a rifle and possibly a pistol. He was never trained in any form of unarmed combat or the use of knives.

10.15 In 1992 G extended his initial 3 year enlistment for a further 3 years. He was however discharged in 1994 for failing to fulfil his training requirement.

10.16 During his TA service G was never posted outside Great Britain or involved in active service.

10.17 The medical assessments of G's fitness to be a soldier show that everything was within normal limits and contain nothing remarkable.

10.18 Other than in relation to asthma, for which he received treatment from his GP and had regular reviews with a practice based nurse, G had no significant contact with health services prior to 2006.

11 Summary of Events

11.1 In February 2006 G was reported as missing to the Police by Z after he failed to arrive for work at Tesco where he was employed as a shelf stacker. His car could not be located and friends had no knowledge of his whereabouts. Z stated that G was trying to lose weight, had taken a drop in pay at work and may be worried about the payments for his car.

11.2 Extensive financial and phone enquiries were made and G was located at a hotel in London. Before this could be confirmed G returned home. He explained that he had stayed in London for three nights to get away from the pressures of work and home.

11.3 The Police advised him to see his GP and to seek support from the HR department of his employer.

11.4 **G's Road Traffic Collision in May 2006 and consequent health issues**

11.5 In May 2006 Cheshire Police attended a collision between a car and a pedestrian in Macclesfield. The pedestrian was G who had been struck by the car whilst crossing a road,

the car then going over his legs. G was taken to hospital with a suspected fractured left leg. At G's request the Police informed his mother of the incident.

11.6 No further information regarding the circumstances of this road traffic collision has been traced. It is believed that G made a civil claim for damages in connection with it but the outcome is unknown and the Solicitor understood to have acted for G has declined to provide any information to the Review without G's consent, which has not been provided.

11.7 At the Emergency Department of Macclesfield General Hospital it was recorded that G had been hit by a "Ford Ka" vehicle travelling at low speed and which had run over his legs. It was established that G's leg was not fractured but had sustained tissue damage. There was no loss of consciousness reported and no indication of a serious injury.

11.8 At an orthopaedic follow up appointment it was noted that both of G's legs were extremely swollen, with a large blister on his left leg, and he was admitted for inpatient treatment of the swelling. No deficit to his circulatory or neurological systems was identified. He was discharged home after 11 days in hospital, at which time he was well in himself and mobilising independently.

11.9 From then until the end of 2007 G was seen by his GP on numerous occasions for recurrent problems with his left leg. He was prescribed antibiotics for cellulitis and referred to specialists in plastic surgery, orthopaedics haematology and infectious diseases at the Royal Stoke Hospital (formerly the University Hospital of North Staffordshire). On a number of occasions G requested second opinions regarding the specialist treatment provided and these were arranged by his GP.

11.10 By early 2007 G was noted to be grossly overweight (with a BMI of 48) and he was given advice on diet, prescribed medication to assist in weight loss and subsequently prescribed gym sessions.

11.11 During 2008 the acute problems with G's legs appeared to have subsided and G was noted by his GP to be obsessed with exercising.

11.12 Between 2010 and April 2013 G was seen by his GP on 15 occasions with periodically recurring leg problems attributable to the road traffic collision. He was again prescribed courses of antibiotics for cellulitis and referred for specialist orthopaedic and plastic surgery assessment. His weight continued to be excessive throughout this period despite dieting and exercise. This was noted to be a contributory factor in his recurrent leg problems.

11.13 From April 2013 onwards G sought no further medical assistance with the consequences of the 2006 leg injuries. Excessive weight was however an ongoing issue for him.

11.14 The primary care report observes that G appeared to have an obsessive character, manifesting in his exercise regime from 2008, and in him seeking multiple courses of antibiotics and second opinions in respect of specialist medical assessments.

11.15 The relevant health service reports all conclude that the treatment provided to G consequent to his leg injury in 2006 was on each occasion appropriate to his presenting conditions.

11.16 **D's involvement with his GP 2006-7**

11.17 In December 2006 D visited his GP with his wife and is recorded as being stable on his anti-depressant medication although occasionally emotional. He declined the offer of a psychiatric referral at that time but did agree to this in February 2007. A referral letter was

sent to North Staffordshire Combined Healthcare NHS Trust (NSCHT)[6] but the need for assessment when D was stable was queried. The referral was not thereafter pursued further.

11.18 **Police Involvement with G - 2007 to 2013**

11.19 On an afternoon in May 2007 G visited Kidsgrove Police Station and introduced himself as 'Tom Brown'. He told an Officer that he wished to provide the Police with information about a conversation that he had overheard and photographs of people he said were acting suspiciously. When asked to verify who he was G did not maintain his pseudonym and produced his own passport.

11.20 G went on to say that in February 2006 he had been shot at in Kidsgrove. There was no record of a shooting in Kidsgrove and no evidence to support G's account of it.

11.21 The information and photographs provided by G were examined and concluded to not merit any further action.

11.22 In February 2008 a representative of G's employer contacted the Police reporting that they had found some suspicious material belonging to G, who was off work due to mental illness but visiting the shop up to three times a day. This material included photographs of members of the public apparently taken by G and suggested that be believed there was a criminal conspiracy.

11.23 The material was examined by the Police and G then spoken with. G told the Police that he had been mentally unwell for two years and it was concluded that G genuinely believed he was helping authorities. He was strongly advised to cease taking photographs of members of the public.

11.24 G's parents were told the reason for the Police involvement. Police also visited G's GP who stated that he was unaware of G's mental health problem but made an appointment to see him.

11.25 The following day G was seen by his GP who assessed him and found no evidence of thought disorder, delusions or hallucination.

11.26 In May 2008 a resident of Kidsgrove reported to the Police finding a Tesco carrier bag in the front garden of their home which contained papers including photographs of members of the public and a photograph of G.

11.27 G was seen and admitted he had left the bag in the garden. He accepted that what he was doing was wrong but said he could not help himself. It was recorded that at that time G was under the care of his GP but there was no contact with the surgery. G was continuing to see

[6] North Staffordshire Combined Healthcare NHS Trust (NSCHT) provides Mental Health, Services to the population of Stoke-on-Trent, Newcastle-under-Lyme and Staffordshire Moorlands.
The Access Team is a single point of contact and access for all NSCHT services which include:

- Teams of qualified Health and Social Care Staff who work together to provide an assessment, advice and sign posting service to support recovery and promote well-being.
- Support for people with mental health problems who are experiencing severe difficulties when the stability of their mental health has been interrupted by crisis.
- Short term crisis intervention and/or home treatment to people to reduce the likelihood of them being admitted to mental health inpatient facilities.
- Work to enable earlier discharge from inpatient care and ensures that all admissions are appropriate and that where possible, the person does not become admitted.

his GP in connection with the manifestation of his leg injury. His mental health was not however, following the assessment in February 2008, being explicitly considered.

11.28 In July 2009 G's car was found unattended in a remote location by North Wales Police. Police contacted Z who got in touch with G. He told her that he was safe and well but his car had broken down, he had been given a lift and he could not then remember the precise location of the vehicle. Z informed the Review that the family had been on holiday in Wales when this occurred and that G had left in his car without saying where he was going. It is known that G did visit remote areas to walk as part of his exercise regime.

11.29 On three occasions between July 2012 and April 2013 Cheshire Police received reports from members of the public that on separate occasions G's vehicle was being driven erratically and at speed in that county. On one occasion G was issued with a verbal warning but on the other two occasions circulation of the vehicle to Police patrols did not lead to it being stopped.

11.30 **Road Traffic Collision – September 2013**

11.31 On an evening in September 2013 two West Midlands Ambulance Service staff witnessed a collision between a vehicle driven by G and another car in Macclesfield. G was witnessed to under-take the ambulance at high speed, crossing lanes and hitting another car on a roundabout at approximately 45 miles per hour. G appeared to have sustained a significant injury to his left leg.

11.32 When the ambulance crew assessed G they found him to be delusional, confused and behaving erratically. G informed them that he was being chased by other vehicles but the ambulance service staff had not seen any such activity.

11.33 They requested that Police attend the incident as they felt that the behaviour of G was concerning and that he may require detaining under the Mental Health Act or restraining for his own safety during his journey to hospital. Such action by the attending Police Officer was not however required.

11.34 G was transported to Macclesfield District Hospital where the ambulance service staff expressed concerns about his mental state, and requested he be assessed for mental illness after initial assessment of his physical injuries.

11.35 At Macclesfield Hospital G was noted to be very confused and was unable to provide an account of how the collision had taken place. There is no record of him exhibiting any other mental health difficulty. Although there was significant swelling to G's lower left leg no underlying injury or movement deficit was identified and he was discharged four hours after his arrival.

11.36 A discharge summary was sent to G's GP, who he visited 5 days later and was prescribed antibiotics for cellulitis.

11.37 G was found by the attending Police Officer to be driving on an expired full driving licence and this was reported to the DVLA. No further action was taken by the Police other than to have G's car recovered when he did not arrange this himself.

11.38 **GP and NSCHT involvement – October 2013**

11.39 On 23 October 2013 Z visited G's GP and reported that he had been behaving strangely for the preceding 6 months, was very withdrawn and hardly ever leaving the house. He was reported to have been banging the window at children next door and had told a neighbour that he was in the Army. She reported having found a knife hidden at the side of a sofa, that he would not talk to her and "did not know she was there". The GP visited G at home that day accompanied by the surgery's asthma Nurse, with whom G was familiar from his asthma medication reviews. G denied having any hallucinations, paranoid ideation, and thoughts of harming himself or others and all of the behaviour reported by his mother. G denied knowing anything about the knife found by his mother. G (falsely) stated that he was still in contact with the TA and that he carried out voluntary work for them. G showed the GP a history book and stated that he tried to remember the dates of wars to keep his mind active. The GP formed the view that G was not showing evidence of a severe mental disorder which posed a risk to himself or others but that he should be further assessed; which G agreed to.

11.40 On 23 October 2013 G's GP referred him to the NSCHT Access Team requesting an assessment of his mental health. The referral was marked as urgent but not sent, by FAX, until 25 October 2013.

11.41 The referral included a copy of the electronic notes written by the GP after the home visit. A health history summary dating back to 1972 was also provided with the referral.

11.42 The NSCHT Access Team concluded that there was no indication from the referral of sufficient symptoms of mental disorder or indicators of risk to suggest that an assessment under the Mental Health Act 1983 should be considered.

11.43 Telephone contact was made with G by an Access Team Mental Health Staff Nurse on 25 October 2013. G stated he did not think he had any mental illness and did not want to take the assessment any further; he declined the offer of any mental health services. The Staff Nurse tried to persuade G to accept an assessment but he was adamant he did not have a mental illness. The case was accordingly closed by the Access Team that day and the GP was updated by letter.

11.44 The decision made by the Staff Nurse was appropriate to the information available and the circumstances. In the absence of grounds for statutory intervention, provision of mental health services is permissive. There was no indication that G did not have the mental capacity to decide whether he wished to access mental health services.

11.45 It is unclear from the records whether the Staff Nurse discussed this case with a senior practitioner prior to closing the case and she is unable to remember whether this was done.

11.46 The NSCHT report identifies that there is now a duty shift leader role within the Mental Health Access Team and that part of their role is to review all urgent assessments with regard to risks identified and severity of symptoms and agree the actions following contact. A recommendation is made that this supervisory arrangement is continued to ensure urgent referrals are dealt with in a timely manner and to provide management oversight of decisions made.

11.47 On 11 November 2013 G's GP spoke with Z who reported no change in G's condition since the home visit on 23 October. The GP then consulted the NSCHT Access Team and was advised that as G did not present as if he was a danger to himself or others his refusal to be assessed would need to be respected. The GP was invited to re-contact the Access Team if the position changed.

11.48 On 22 November 2013 Z had a further conversation with the GP and reported that the situation had still not changed. G was stated to have largely stayed in his room and avoided all contact with her. The GP visited G's home on 26 November 2013 and G came downstairs to speak with him. He had lost 1.5-2 stone of weight and stated that he was restricting his calorie intake by staying in his room to avoid temptation to eat. G agreed to interact more with his family.

11.49 D informed that GP that bailiffs had visited the house earlier that day and had demanded payment from G for an unpaid fixed penalty for going through a red traffic light and that Z had paid this for him.

11.50 G also opened a letter in the presence of the GP, who noted that it was from an insurance company and referred to a road traffic collision in September 2013. The letter stated that as G did not have a valid driver's licence his insurance was void. G denied having been in a collision and stated that the Police had taken his car away after pulling him over with balance problems and that it must have been in an accident subsequently. The GP recognised that G's account of events leading to his car being damaged was untrue but did not identify any evidence of a serious mental health problem.

11.51 The GP agreed to see G again if there were further concerns regarding his mental health. No such concerns were brought to the attention of the GP or identified during the four GP appointments that G attended over the following 11 months for review of his asthma medication.

11.52 **Death of D**

11.53 On an afternoon in October 2014 Z was at work when she received a telephone call from D who asked her to "get the police quickly". She was concerned for his welfare and immediately contacted the Police. During the call Z told the Police call taker that she had been having problems with her son for the past two years and that he had mental health problems.

11.54 On arrival at the family home the attending Police Officer was met by G who was heavily blood stained and holding a knife. G responded to the Officer's instruction to put the knife down and was arrested.

11.55 D was found bleeding profusely from serious stab wounds to his body and throat. First aid was given to D by the Police and then by Paramedics and a Doctor but this was unsuccessful and D was confirmed dead at the scene.

11.56 When interviewed by the Police G maintained that there had been no prior physical fights between him and D, only verbal exchanges, the last one being six month before. This had followed the visit by his GP and the asthma nurse from the surgery. Since then D was stated to have been fine with him and they watched TV together the day before the incident.

11.57 G stated that on the day of his father's death his mother had been at home during the morning before leaving for her work at 12 noon. G then did his normal chores which involved hoovering and dusting. He was in his bedroom tidying up when his father came upstairs and told him that he was 'sick and tired' of him being at home and wanted him gone from the house. A verbal argument developed which became physical and G described fighting with his father. G said his father kicked him on the left leg, his 'weak spot'. His father came at him with a knife and G disarmed him.

11.58 There were then further verbal exchanges with D saying G was 'no good at anything' that they had tried all kinds of ways to help him but he 'couldn't do anything'. G then said "out of frustration the knife goes into his neck."

11.59 During the Police interview G referred to his parents as Mr (surname) and Mrs (surname). When asked why he was using this form of words G stated that it was because he was adopted at birth. He volunteered that the DWP (Department of Work and Pensions) had investigated the family because of arguments with his father. G blamed his father's PTSD for the arguments and said his father should be in a less stressful environment.

11.60 G said he had got the injury to his left leg after being shot down in a helicopter in Iraq whilst serving in the Royal Army Medical Corps with the Territorial Army. It was put to him that he was injured after being struck by a car as a pedestrian but he maintained that his account of the helicopter crash was correct.

11.61 G was subsequently charged with the murder of D.

11.62 In September 2015 Stafford Crown Court accepted medical advice that G was suffering from paranoid schizophrenia and unfit to stand trial. A hearing of the facts was however held and the jury decided that G had unlawfully killed D. G was ordered to be detained in a secure hospital.

11.63 **Perspective of Z on G**

11.64 Z stated that the relationship which she and D had with G had generally been good.

11.65 Following the 2006 road traffic collision G's behaviour was reported to have changed with him becoming more withdrawn from about 2010, when he started spending more time in his room and shouting about things.

11.66 From 2012 G was reported to have started talking to himself all the time although his mother could not understand much of it. This seemed to be getting more serious and made her concerned enough to seek assistance from the GP in October 2013. She stated that before the GP was called she saw a knife about 11 inches long in the corner of G's armchair. She removed the knife and hid it.

11.67 Z explained that she had always thought of G as a loner but did not think he had any mental health problems until about 2 years before D's death. She stated that there was then a definite change in him, he would talk and laugh to himself as he read a book, and he gradually got worse.

11.68 Z recounted that when Bailiffs had visited to obtain payment for a debt G had told her that he had not paid a penalty notice for going through a red light but she did not know if that was true. She had paid the bailiffs and G then paid her back. Z believes this problem arose because G often ignored his mail for long periods.

11.69 Z stated that after this G was upstairs for a month and she was unsure if he was eating or not as he was trying to lose weight and his diet became unusual, eating only bananas one day then a normal meal the next.

11.70 D and G were reported to have been tolerant towards each other and there had never been any incidents of physical violence. There had been an argument 2 years prior to D's death where G was shouting and D told him to get his belongings and get out of the house. G did so but spent the night in his car on the driveway.

11.71 Z stated that G was able to control the presentation of his mental ill health when in contact with professionals and provide plausible explanations for his behaviour. She did however have concerns that G's condition could deteriorate further and was concerned enough to take her mobile phone to bed.

11.72 Z advised the Review Panel Chair that she felt that her concerns, as a parent, for G's mental health were undervalued because he was an adult. She considered that having a detailed record of his presentation may have helped to counteract his plausibility when denying that there was a problem. She suggested that a prompt by health professionals that family members in similar situations to maintain a detailed record of their relative's behaviour would be a beneficial.

11.73 The Review Panel were pleased to adopt this suggestion as a recommendation from this Review.

11.74 **Neighbours' perspective on G**

11.75 Four neighbours of the family provided evidence to homicide investigation.

11.76 An 11 year old girl told the Police that she regularly walked past the family home and on one occasion in early September 2014 a male in the front garden had shouted loudly at her "Oi don't come round here again". The male was holding a spade which he did not raise or use to threaten her but he moved from the front garden onto the footpath. He shouted at her a second time "Don't come round here again, who do you think you are?" She was intimidated and frightened by the man's behaviour and told her friend's mother. The matter was not reported to the Police.

11.77 A second neighbour has a view of G's address but had no direct contact with him. For two weeks prior to the death of D the neighbour had noticed G standing in the front bedroom window looking out onto the street most evenings for hours at a time.

11.78 A third neighbour said he had not had any meaningful conversations with G but had spoken with D and Z. He believed that G had some kind of mental health condition and it was linked to a car accident that G had in which G's girlfriend died, although he could not recall who told him this. Whilst outside the house, he had heard G swearing under his breath but did not believe the swearing was directed towards him. He had heard G swear from the upstairs bedroom window at people who passed the front of the house or just swear for no apparent reason. He reported that Z told him they tried to get help for G regarding his mental health but he would never cooperate and she felt the family had to deal with the situation on their own.

11.79 A fourth neighbour described having spoken on a number of occasions to G who was usually quiet. He had seen G during the past couple of years standing in his bedroom window staring into the street. Whilst out in his garden during August 2013 the neighbour was approached by G who had a very determined look on his face and said to him "Why have you been telling lies about me, I have been speaking to people who told me that you said I have never been in the Army". The neighbour denied having said any such thing at which point G reeled off some Army abbreviations in a loud voice and went back inside his house.

11.80 None of these neighbours witnessed any violence from G or viewed the recalled episodes as serious enough to be reported to the Police.

FINDINGS AND CONCLUSIONS

12.1 The Review Panel concluded that there was no basis on which the killing of D by G could have been predicted by any agency or on which they could reasonably have acted to prevent it.

12.2 Z, D and G appear to have been a close knit family with few interests outside of their home and receiving few visitors. There is no known history of violence by any of the family members and nothing was brought to the attention of any agency in the 11 months prior to the killing which might have suggested that it would occur.

12.3 It is clear that by May 2007, and probably earlier, G was suffering from a mental disorder and that the severity of this, which was diagnosed as paranoid schizophrenia following his arrest for the killing of D in 2014, increased over time.

12.4 Whether there was a direct causal relationship between G's involvement in the 2006 road traffic collision and his mental disorder has not been confirmed. It does however appear highly likely that the impact on G's mobility, weight and lifestyle of the injuries sustained contributed to the deterioration in his mental health.

12.5 The manifestation of G's mental disorder as a preoccupation with national security issues in 2007-8 was taken seriously by the Police but responded to proportionately. Within this response the direct engagement of G's GP to assess his mental health in February 2008 was good practice. When G again came to the attention of the Police in May 2008 it would have been appropriate to re-contact the GP and reinforce concerns regarding G's mental health.

12.6 Apart from the driving of his car in an erratic manner between July 2012 and September 2013 the only indication that G might pose a risk of harm to others was when his mother found a knife secreted by a sofa in October 2013. G denied any knowledge of this and his GP found no evidence of him having a serious mental disorder which posed a risk to himself or others, a view supported by the Mental Health Access Team. G's presentation accords with that when he had previously been assessed by his GP in February 2008 and, in all likelihood although not explicitly recorded, when at the Macclesfield Hospital Emergency Department in September 2013.

12.7 It seems likely that these findings may reflect G's ability to control the manifestation of his mental disorder. Nevertheless there was no evidential basis on which G could have been detained under the Mental Health Act 1983 during the period under review.

12.8 G could have voluntarily accessed services for his mental disorder either through his GP or directly with the Mental Health Access Team. In October 2013 the Mental Health Access Team attempted to persuade him to do so but without success. However, as observed by the Mental Health Access Team at that time, as G did not present as a danger to himself or others his refusal to be assessed would need to be respected.

12.9 D suffered from PTSD consequent to his experiences in the British Army. The treatment provided to him for this condition was appropriate. The Review found no indication that D's Army service or his PTSD played any part in the attack which led to his death.

12.10 There is similarly no indication that G's involvement with the Territorial Army contributed to the deterioration in his mental health or played any part in him killing D.

12.11 Finally, there is no indication that either D or G required or were provided with care by other family members which went beyond their normal contribution to family life. Accordingly there was no basis on which any professional should have considered conducting an informal carer's assessment.

RECOMMENDATIONS

13.1 The Review Panel made one recommendation from their consideration of this case and at the suggestion of Z:

That providers of primary care and mental health services should include in their assessment pathways a prompt for maintaining a detailed recording of an individual's presentation by family members concerned about their mental health.

13.2 North Staffordshire Combined Healthcare NHS Trust (NSCHT) made one further recommendation; for the continuation of the duty shift leader role in the Mental Health Access Team to ensure that urgent referrals are dealt with in a timely manner and have oversight of decisions made around actions and outcomes.

13.3 Implementation of the action plan from these recommendations will be monitored under arrangements agreed by the Newcastle-under-Lyme Community Safety Partnership.