DOMESTIC HOMICIDE REVIEW SOLIHULL

DHR 2 Overview Report

Simon Hill: Independent chair and overview author

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This report contains pseudonym names to protect the identities of the deceased and their family.

1. Introduction

1.1 Summary of the circumstances leading to the Review

1. The incident occurred at 0334 hours on 7 July 2014. Ambulance Control contacted the police and requested their assistance at home address 1, as a 'suicidal psychiatric patient' (Jack) was in possession of scissors and was threatening to stab both the paramedics and then himself.
2. Uniformed response officers attended and having liaised with the parties present, concluded that there was no role for the police at that time. They subsequently left the premises along with paramedic leaving the patient with his parents.
3. At 0517 hours that same day, a female (Julie) telephoned the police. She was screaming and stated that her brother was self-harming. She had locked herself in the bathroom of the house.
4. At 0523 hours Police received a further call from Ambulance Control in relation to home address 1, reporting that a male had stabbed his mother.
5. Officers immediately attended the address and subsequently discovered the bodies of Anna and John. The same young male (Jack) was present at the address. He was suffering from what appeared to be self-inflicted injuries. He was arrested on suspicion of murdering his parents.

1.2 Subjects of the Review

1. The victims were: Anna and John. The perpetrator was their son, Jack there were two siblings; another son, David and a daughter, Julie.

1.3 Purpose of the Review

1. Safer Solihull Partnership conducted this review in response to the requirements of Section 9 of the Domestic Violence, Crime and Victims Act (2004.) This creates an expectation for local areas to undertake a multi-agency review following a domestic violence homicide (DHR). This provision came into force on 13 April 2011.
2. Domestic homicide review means 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) A person to whom they were related or with whom they were or had been in an intimate personal relationship.

b) A member of the same household as themselves.

3. They are held to examine the case in question by involving practitioners, agencies, friends and family in order to identify any learning that may be implemented to contribute to prevention of such crimes in the future.
4. The case in question relates to the death of Anna and John. The Chair of Safer Solihull Partnership and partners have assessed the circumstances of their deaths against the Home Office definition, detailed below.

1.4 Criteria for holding a review

1. The definition states that domestic violence and abuse is: '*any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass, but is not limited to, the following types of abuse: Psychological, Physical, Sexual, Financial and Emotional.'*

2. Controlling behaviour is*: 'a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.'*
3. Coercive behaviour is*: 'an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim.'*
4. This definition, which is not a legal definition, includes so-called 'honour' based violence, female genital mutilation (FGM) and forced marriage.
5. A Domestic homicide review should be undertaken when 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) a person to whom he was related or with whom he was or had been in an intimate personal relationship, or (b) a member of the same household as himself, held with a view to identifying the lessons to be learnt from the death.
5. It should be noted that an '*intimate personal relationship'* includes relationships between adults who are or have been intimate partners or family members, regardless of gender or sexuality.
6. A member of the same household is defined in section 5 (4) of the Domestic Violence, Crime and Victims Act [2004] as: (a) a person is to be regarded as a "member" of a particular household, even if he does not live in that household, if he visits it so often and for such periods of time that it is reasonable to regard him as a member of it; (b) where a victim (V) lived in different households at different times, "the same household as V" refers to the household in which V was living at the time of the act that caused V's death.

1.5 The Domestic Homicide Review process

1. The Safer Solihull Partnership Chair sat on Monday 28th July 2014 to consider the circumstances of the incident and to determine whether or not it was appropriate to conduct a Domestic Homicide Review in line with the definition of domestic homicide as defined in the Domestic Violence, Crimes and Victims Act 2004. She took advice from the practitioners of the Solihull Domestic Homicide Panel who had met on 24th July 2014 to consider the case and offer advice to the chair.
2. The chair and panel also considered, on the basis of replies received to date, which agencies had been involved with the family and the relevance of this involvement with the incident. They used this information to determine which agencies should be involved within the review and be requested to conduct Individual Management Reviews (IMRs).
3. The Chair and panel also considered the involvement of family members and others in the process.
4. The decision to hold a Domestic Homicide Review was made by the Chair of the Safer Solihull Partnership on 28th July 2014, as the circumstances of the death fulfilled the criteria to conduct a Domestic Homicide Review as defined in the Domestic Violence, Crimes and Victims Act 2004.
5. The Independent chair, Anne Cole, led the review in the preparation of the terms of reference and chaired panels on the 4 August 2014, 29 October 2014 and 28 November 2014. The panel meetings considered the Individual Management Reviews and sought additional information to assist learning.
6. Due to personal reasons, the chair Anne Cole, informed the chair of the Safer Solihull Partnership that she would not to be able to continue in her role and asked that a new chair be appointed.
7. The new chair, Simon Hill was identified and appointed in February 2015. The new chair led panel meetings on the 19 March 2015 and 13 August 2015, 25 January 2016, 20 May 2016 and held the meetings with family members.

1.6 **Parallel Processes**

1. The panel was aware of the on-going criminal proceedings and therefore the terms of reference were shared with the Senior Investigating Officer (SIO) to ensure there were no disclosure issues raised.
2. As a result of the homicides, and in line with the requirement that where there has been a death or serious injury, and that person(s) had contact of any kind with a person serving with the police that may have caused or contributed to the death or serious injury; an Independent Police Complaints Commission (IPCC) enquiry was started. The IPCC concluded that this matter was suitable for local resolution and the enquiry only had a temporary impact upon the Domestic Homicide Review timescales.
3. The Safer Solihull Partnership informed Her Majesty's Coroner of the commissioning of a Domestic Homicide Review.

1.7 **The Domestic Homicide Review panel and Independent Chairs and Overview Author**

1. The panel was formed from the following representation:

- Solihull Council Community Safety Manager
- Solihull Council Domestic Abuse Co-ordinator
- Solihull Clinical Commissioning Group- Designated Nurse Safeguarding Adults & Children
- West Midlands Police Public Protection Unit Detective Inspector
- NHS Area Team
- West Midlands Ambulance Service Head of Safeguarding
- Birmingham and Solihull Mental Health Trust
- Heart of England Foundation Trust- Safeguarding
- Birmingham and Solihull Women's Aid
- Staffordshire and West Midlands Community Rehabilitation Company

2. The independent panel chair and overview author, Simon Hill is a retired police public protection investigator with twelve years' experience of child and adult safeguarding and major investigations. Prior to leaving the police service he managed the Public Protection Review Team, responsible for writing the force's Individual Management Reviews and contributing to over thirty Domestic Homicide Reviews and child and adult Serious Case Reviews (SCR's.) He has chaired several Domestic Homicide Reviews and adult Serious Case Reviews in the region. He has had no involvement with the case subject of this Domestic Homicide Review.

1.8 Scoping the Review

1. The following agencies were asked to search their records to establish what contact they had had with the victims, perpetrator or immediate family members:

- West Midlands Police
- West Midlands Ambulance Service
- NHS England
- Birmingham & Solihull Mental Health Foundation Trust
- Solihull Clinical Commissioning Group
- Heart of England Foundation Trust
- Staffordshire and West Midlands Probation Trust
- Hertfordshire Police
- Hertfordshire Mental Health Forensic Services
- Education Services to include school and college services
- Manchester Metropolitan University services
- Birmingham and Solihull Women's Aid

2. Where there was no involvement or insignificant involvement, agencies advised accordingly. All agencies were asked to provide a chronology of involvement to assist the review panel.

1.9 Time period

1. Agencies were asked to consider all relevant records relating to the subject and identified family members, for the period 1 September 2006 to 7 July 2014 the date on which the homicides occurred. The start date was selected in order to capture any relevant information whilst Jack was attending school.

1.10 Individual Management Reviews (IMRs)

1. As a result of the initial scoping exercise, Individual Management Reviews were requested from the following agencies:

- West Midlands Ambulance Service NHS Foundation Trust
- West Midlands Police
- Hertfordshire Constabulary
- Birmingham and Solihull Foundation Mental Health Trust
- Solihull Clinical Commissioning Group
- Heart of England NHS Foundation Trust
- Youth Offending services

2. Reports were also received from:

   Hertfordshire County Council reviewing the actions of staff providing services in relation to the in-custody mental health assessment of Jack.

   Manchester Metropolitan University

   West Midlands Ambulance Service table top review by Mental Health Street Triage Team

Individual needs

1. Home Office Guidance requires consideration of individual needs and specifically:' *were procedures sensitive to the ethnic, cultural, linguistic and religious identity of the victim, the perpetrator and their families? Was consideration for vulnerability and disability necessary?'*

2. Section 149 of the Equality Act 2010 introduced a public sector duty which is incumbent upon all organisations participating in the review namely to; *eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under this Act, advance equality of opportunity between persons who share relevant protected characteristics and persons who do not share it, foster good relations between persons who share a relevant characteristic and persons who do not share it.'*
3. The review gave due consideration to all the protected characteristics under the Act. The review sought guidance from cultural advisers with experience of South East Asian communities within the West Midlands including an Equality and Inclusion Manager from West Midlands Police.
4. In the limited engagements agencies had with the victims and perpetrator the review found no evidence of discriminatory practice in relation to race, culture or ethnicity. It seems likely that John was excluded from participation with agencies because of his poor command of English. The review found no evidence that this was taken into account, and it appeared that Anna would have spoken on his behalf.
5. None of the Individual Management Reviews identified good practice by their staff that may have demonstrated that they took into account cultural attitudes to mental health, although this is not to say that individual professionals were not sensitive to issues of race, ethnicity or culture and language.
6. The surviving family did not identify any discriminatory behaviour on the part of the agencies they came into contact with.

1.11 **Terms of Reference**

The full terms of reference are included in the appendices.

1.11.1 Terms of Reference for the Individual Management Reviews and Key Lines of Enquiry

1. To establish whether it was known, or could have been suspected that Jack posed a serious risk to Anna or John and whether any action could have been taken to prevent the homicides.
2. To establish, therefore, whether the homicides were predictable or preventable.
3. To establish whether information was known or could have been established through disclosures by David or Julie that Jack posed a serious risk to Anna and John and whether any action could have been taken to prevent the homicides.
4. To identify how effective agencies were in identifying the risks that the alleged perpetrator, Jack, posed, and how effectively such risks were managed if identified.
5. To establish how well agencies work together and to identify any gaps and/or changes that are required to strengthen inter-agency working; practice; policies; or procedures to improve the identification and protection of people subject to domestic abuse within Solihull.
6. To establish what knowledge agencies had that indicated that Anna and / or John might be a victim and Jack a perpetrator of domestic abuse; and how did agencies respond to this information?
7. Were there issues in relation to capacity or resources in agencies that impacted on the ability of the agency to provide services (to the victims, perpetrator or any family member) or which impacted on the agency's ability to work effectively with others?

2. The Surviving family

2.1 Family involvement in the Review

1. The review identified three family members whom the panel believed should be given the opportunity to contribute to the review. These were the two surviving children (David and Julie), of the victims (Anna and John.) The

brother of Anna, (Andrew) had the most frequent and sustained contact with the family. He was asked to represent the views of his parents. (Mother and Father to Anna and Andrew, Grandparents to Jack, David and Julie.. Extended families of both victims were identified living in Holland and the USA, however they apparently had little contact with either victim. Communication was facilitated initially through the Family Liaison Officer (FLO) of West Midlands Police.

2. It had been identified with the Family Liaison Officer that because of the vulnerability of the surviving children, their uncle (Andrew), would act as an intermediary between the review and the family. The original chair wrote in August 2014 to Andrew, describing the process and offering the opportunity for the family to engage with the review. However it was made clear that any extended engagement would be after the trial of Jack.
3. In the aftermath, the incident was subject to scrutiny by the Independent Police Complaints Commission (IPCC) because of the police involvement with the victims and perpetrator immediately before the homicides. Andrew chose to defer any decision on engagement until after the IPCC enquiry and the completion of the trial. David was identified as vulnerable due to behavioural and mental health issues and had declined to be involved. Julie expressed the view that she presently wanted to concentrate upon her recovery and commit to her studies.
4. Following the completion of the trial and sentencing of Jack, and the change of Review chair, in April 2015 the offer to participate in the review was renewed to David, Julie and Andrew.
5. Andrew and his wife met with the Chair and the Community Safety Manager for the Safer Solihull Partnership, together with an advocate from Advocacy after Fatal Domestic Abuse (AAFDA) on the 15 June 2015 and again on 25 February 2016.
6. As a result of the first family meeting, the AAFDA advocate and Andrew spoke with Julie who subsequently agreed to participate. She met with the Chair and Community Safety Manager on the 24 June 2015 supported by a

friend who had been present during the incident of 5 July 2014 (the arrest of Jack following an incident on a London-bound coach.)

7. No other family or friends of the victims have expressed a desire to participate in the Domestic Homicide Review.

2.2 Family information

1. Julie spoke openly and movingly about the family history and her upbringing in the family home in Solihull. Her perspective upon key events will be identified throughout the review. She is the only surviving family member who witnessed the acute mental health crisis suffered by Jack, which led to the key episodes from the 5 July 2014 to the 7 July 2014.
2. Andrew was able to give some understanding of the cultural background of his sister, Anna. He was in regular contact with Jack before the incident and remains in contact with him. He provided his interpretation of the family dynamic based upon contact with his sister, her husband and the children. He also was able to summarise the views of the parents of Anna.

2.3 Family views and wishes

1. Julie stressed that emergency responders should have sought to engage with her as the caller for service and should have been more observant, asking more questions of all concerned.
2. She also felt that if information (in multilingual form) had been available to her mother, explaining in simple terms the types of mental health interventions available and the rights of mentally vulnerable individuals, it may have gone some way to allay her prejudices and fears of mental health services.

3. The Facts

3.1 Family history and community context of the victims

1. Anna was Vietnamese and John was Malaysian. (Anna's family arrived in the UK from Saigon in 1979, and moved to Solihull in 1980.) They met in the UK at the restaurant where Anna worked at weekends. They were married in 1988. Their relationship did not get the immediate support of their families; however Anna was apparently strong willed and persisted in her choice of partner. Their early-married life was marked by financial difficulties. They lived for a period in poor rented accommodation in Sparkbrook, Birmingham, before moving in with Anna's parents in Solihull. Their marriage endured and apparently in time, Anna received the blessing of her mother.
2. Jack, was born in 1990, and as the first grandchild, spent a lot of his early years with his grandmother whose own son, Andrew, had just left home for university. He was shown a lot of affection and *'fussed over'* by his grandmother. Jack latterly formed a bond with his uncle that endured into adulthood. Andrew clearly took pride in respecting and listening to the wishes and views of his nephews and niece.
3. Anna spoke Cantonese to her husband, who spoke little or no English. To her children she spoke almost exclusively in English. Consequently the children had an understanding of conversational Cantonese, but could not write or read the language. Julie said she could understand 'most' of what was said between her parents.
4. The family moved to home address 1 in Solihull where the homicides occurred. David was born in 1993, and his sister Julie in 1996. The home had three bedrooms. John always had a room to himself, Anna sharing a bedroom with Julie, and later with David. Julie remembered sharing her room with Jack from when she was about 16, until he left for university. (She shared the room again with her brother when he returned home, up to and including the tragic events of July 2014.)

5. The children attended local schools. Although there are small South East Asian communities in the area, according to Julie, the family had little to do with their cultural roots. Although Anna's parents lived nearby, it does not appear the family had close friends from within their community, or strong relationships with neighbours and local people. This was determined in no small part by their mother's drive for them to achieve more than she and their father had, leading to a very busy but isolated home life.
6. John worked unsociable hours in restaurants around Birmingham and was kind, quiet and withdrawn, taking little part in decision- making or in the day-to-day running of the home. Anna was the only driver and consequently spent a lot of time dropping and picking up the family. She had worked in local men's outfitters and also as a ward hostess at a local hospital.
7. Anna was described by her daughter as *'the boss of our home.*. In conversation with the author, both Julie and Andrew described Anna's personality and demeanour in very similar terms.
8. They recognised that Anna wanted the very best for her children, pushing them to achieve in both academic and pastoral activities. Although Jack was the gifted musician, all the children were expected to learn instruments. Their mother's measure of success was their obtaining good degrees leading to well-paid jobs with the status and recognition that she perhaps had not been able to achieve.
9. Anna apparently had clear views as to how this would be realised and allowed no discussion. This brought her into frequent conflict with all her children, but particularly with Jack and David. Andrew apparently sometimes tried to persuade his sister to listen to her children but to no avail. Julie and Jack therefore formed a very close relationship. According to Julie, the children could not and would not go to their parents to discuss any concerns. Their father would not go against the wishes of his spouse and would defer to her in everything. Anna when challenged would very quickly become very loud and confrontational.
10. As the boys grew up, the conflicts allegedly intensified and according to Julie, they were both keen to move away and gain independence. Julie by her own

admission was more compliant, submitting to the strict regime her mother imposed.

11. In the last few years, she became the focus of her mother's aspirations for success as both David, and latterly Jack, failed to meet their mother's expectations. However Julie recognised her isolation from peers, which became more significant as she sought independence. She told the author; '*I felt different to my friends I was not allowed to go to sleep overs or go to parties. She never said why really but she was over protective*. '
12. It is clear from speaking to Andrew that although he and his sister would be in regular contact (he would visit when coming to see his parents) she did not share or discuss any concerns with him. Their parents felt their daughter was too severe with her children.

3.2 Key episodes based upon the chronology of agency involvement

1. There were very few agency contacts with the family during the period under review; the majority related to health issues. (John had a life-limiting illness immediately before the homicides.)
2. Amongst these however, were health concerns in relation to David, described in **section 3.3 Early Involvement,** that are relevant in that they offer some, albeit slight, indication of Anna's attitude to mental health and the services on offer. The panel felt they may help to inform the analysis of the very short period described below in detail at section **3.4 The Mental Health Crisis (July 2014.)**

3.3 Early involvement

1. There was little in the history of Jack that could have given rise to serious concern about his mental health. As an adolescent he was quite frequently in trouble at school, where he would sometimes get into fights. (In March 2009 Jack was treated for head injuries in hospital having been involved in a fight.)
2. He was permanently excluded from school in September 2005 for threatening other pupils and firing a BB gun in school.

3. In 2006 Jack, came to notice of police in relation to allegations of shoplifting and again in 2008, when he received a final warning. At the time, he disclosed to the custody officer that '*he has self-harmed on one previous occasion due to problems with his parents, whom he regards as the sole problem in this regard.'* It is not possible to tell whether police referred the concern to social care, since neither agency has maintained records from the period. However there is no record of social care engagement with the family at that time. The opportunity to place a 'self-harm' marker on Police National Computer (PNC) was not taken.
4. Jack's younger sibling, David had communication and hearing difficulties. He had a marked stammer. During his schooling he wore hearing aids, and in 2007 his Statement of Educational Needs described delayed English language development, ascribed in part to these difficulties but also because it was his second language, rather than any learning difficulty. His family considered he was autistic or had Asperger's syndrome.
5. In September 2010 Jack started a BA (Hons) Music/Sport Development degree at Manchester Metropolitan University (MMU) at the Crewe campus. He immediately changed to study music as a single honours course.
6. The Learner Development Service of the university reported that upon enrolment, Jack declared that he had a '*specific learning difficulty such as dyslexia, dyspraxia, or AD(H)D.*' However he never sought specific support nor cited it as an '*exceptional factor'* which could have been taken into account by the Exam Board. The Domestic Homicide Review panel has found no other indications that Jack had learning difficulties.
7. Jack's university career was troubled. He failed to complete the first year course and re-enrolled in 2011. He was involved in an incident of academic misconduct that was characterised as poor academic practice. His tutor (now retired) recollected in a submission to Manchester Metropolitan University, which was provided to the Domestic Homicide Review, that he had financial problems and parental problems because they were 'strict'. He remembered other potential problems with alcohol and drugs use and possibly a relationship problem. (With hindsight it is reasonable to assume that Jack's

use of marijuana started around this time.) During his second year, Jack was travelling to University from the Hamstead campus run by Birmingham City University (BCU).

8. In January 2012, David was referred by his GP to the Community Mental Health Team (CMHT) after he reported hearing voices which led to concerns that he may develop psychosis. Julie described to the chair these episodes of what she considered to be '*strange behaviour* 'indicative of a mental health issue. Her brother would sit in his room laughing and talking to himself. He had problems sleeping, and got up in the middle of the night and could be heard '*banging about the house*.' She apparently spoke to her mother, who was well aware of the problem since she was sharing a room with her son. Julie recollects that her mother did not want to acknowledge mental health issues, but rather felt the root cause was her son's stammer.
9. An assessment in February 2012 concluded that the Early Detection and Intervention Team (EDIT) would provide support. (EDIT specialised in dealing with young people showing early signs of psychosis.)
10. The records show that David believed he was developing paranoid schizophrenia and was willing to take anti-psychosis drugs. Anna was recorded in medical notes on several occasions in June 2012 as being '*unhappy*' with this form of treatment.
11. By September 2012 the team were considering an assessment process around Autistic Spectrum Disorder (ASD). David was reporting increasing conflicts with his mother, who wanted him to do his homework, take part in domestic chores and achieve a university place like his brother.
12. The conflicts reached crisis point in July 2013 when David left home and moved to a hostel. Julie recollects rows with her brother that centred upon him accusing her unjustly of name calling and spying on him. She recollects that he had researched benefits entitlements to facilitate his moving out. She appears to have had little or no contact with her sibling since this time. Anna had only limited contact with her son thereafter. As late as January 2014 David was telling the psychological therapist at the Early Detection and

Intervention Team with whom he had been working from the outset, that he was hearing voices.

13. In 2013 Jack enrolled for a year of study at university in Birmingham. The Domestic Homicide Review has not been able to identify the college Jack attended and neither Julie nor Andrew are able to assist. He then shared rented accommodation in Perry Barr with friends. Their identities have not been established therefore little is known about this period. However with hindsight it is clear that he was not working, amassed considerable debts and according to his uncle had no entitlement to benefits. He did not ask for financial support from his family.
14. Jack's tenancy in Perry Barr ended in June 2014 and he was obliged to move back to his parents' address. He did visit his uncle for about a fortnight in early June 2014. At that time, Jack was disorientated and '*lost*' and he slept-in late every day. However there were apparently no indications of mental health concerns. He was encouraged by his uncle to consider applying for jobs in London and moving down permanently. A date was set; 21 July 2014, Andrew recollected that this would coincide with a trip to Solihull to help take his mother (grandmother to Jack) to hospital.

3.4 The Mental Health crisis (July 2014)

1. It is clear that when Jack moved back home, considerable family tensions resurfaced. Apparently conflict broke out between Jack and his mother as she expressed her frustration and disappointment with him.
2. Julie, in conversation with the author identified with hindsight, in the month prior to the homicides, the early indications of the mental health crisis that occurred. Her brother became increasingly reclusive, and stopped going out. He would sit on his computer with the curtains drawn. He had previously earned money busking in the town centre, but stopped doing this in June 2014. He apparently took little care of himself. He would apparently '*smoke a lot of weed*'. Julie knew he was' *in trouble*', having to pay back money for drugs, drinking, smoking and rent arrears. Letters remained unopened. The

previous close relationship deteriorated and Jack would not listen to Julie when she told him to seek help.

3. Apparently Anna's response was to tell her son to '*sort himself out*' and '*get a job.*' There were repeated arguments where Anna would apparently shout and '*stay angry* 'for a considerable time.
4. In the week before July 7 2014, Jack spoke of hearing voices. Julie told her mother they needed to get her brother to a doctor, but she apparently resisted, saying they would *'drug him up.'* If this was indeed the first time that the family became aware of the auditory hallucinations, the reality would appear to have been somewhat different. When Jack was subject to assessments in custody after the homicides, he acknowledged he had been '*hearing voices'* since January 2014.
5. Anna believed that both her son and daughter could become rich through a modelling career. Apparently Jack had previously been 'scouted' by an agency but lost the opportunity. Anna therefore arranged a trip to London by coach to go to an agency open morning and do some sight-seeing. Andrew had been informed the night before, and was expected at short notice to facilitate the visit as guide.

3.4.1 Arrest and detention of Jack: Custody Mental Health Assessment

1. On Saturday 5 July 2014, Anna, her son and daughter and Julie's school friend took a coach to London. They were seated separately, and Julie recollects Jack was nervously looking round at other passengers. It is apparent with hindsight, that Jack's mental state led him to believe there was danger or threat from the fellow passengers and that they would be harmed if they continued the journey to London.
2. The bus was travelling on the M40 motorway, when he approached the driver and asked to be let off. He was told this was not possible. Julie woke her mother as this was happening, and she followed her son and persuaded him to return to his seat. However he soon returned to the front of the bus, carrying a small pair of scissors in a multi-tool and demanded to be let off the bus. The driver stopped and let him alight and his mother followed him.

3. The driver called the local police (08:48) and would not let Anna and Jack back on the bus, moving along the hard shoulder when Jack approached the vehicle. Julie recollects being encouraged to stay on the bus by other passengers. An armed response vehicle attended and Jack was arrested for affray and possession of an offensive weapon and at 09:18 he was taken to Watford police station. He was apparently calm and compliant.
4. Hertfordshire Constabulary Individual Management Review acknowledged that because of the nature of the call and the difficulty and possible danger of keeping a coach full of passengers on the hard shoulder, no statements were taken from the driver or passengers nor indeed, any of Jack's family.
5. The remaining party stayed on the coach and continued their trip to London. Anna called her brother several times disclosing that Jack had threatened the driver of the bus. She asked him to help.
6. On arrival into custody Jack stated to the custody officer that he had heard voices in his head immediately before the incident. He did not disclose any mental health issues, nor did he acknowledge use of drugs or drink. He did disclose his one self-harm incident.
7. At 10:45 Jack was seen to be attempting to cut his wrists with his notice of rights and entitlements and also attempted to bite both wrists. His clothes were removed and he was put into an anti-self-harm suit. At 11:13 he was subject of an informal medical examination where the custody nurse concluded he was fit to be detained but not interviewed or charged and required constant observation. Jack disclosed that he felt there were people '*out to get him*.'
8. At 15:50 a doctor who was a Force Medical Examiner (FME) conducted a mental state examination. The Force Medical Examiner concluded that a full Mental Health Act Assessment (FMHAA) was required. Jack apparently told him that he had smoked a lot of cannabis in the week preceding his trip to London. The doctor agreed with the earlier assessment and added that Jack was at increased suicide risk and that constant observation should be maintained. The doctor also concluded that Jack required an appropriate adult.

9. Hertfordshire County Council provided the Domestic Homicide review with a report specifically concerning the assessment. The Independent Approved Mental Health Professional (AMHP) discussed the case with a Specialist Registrar and with the Force Medical Examiner to assess whether in view of Jack's apparent cannabis use, a Full Mental Health Assessment could take place. They concluded it could. The Approved Mental Health Professional established through the Solihull Mental Health Crisis Team, that Jack was not known to their services.
10. The Approved Mental Health Professional, the Registrar and a section 12 Mental Health Act GP[1] conducted a full mental health assessment at 20:47. No independent appropriate adult was present or requested. Jack was very calm during the assessment, made '*good eye contact',* smiled 'at *the right times.'* Jack admitted to cannabis use for about a year. The Approved Mental Health Professional review concluded that he had '*experienced a drug induced psychotic episode which had now* passed.' He was advised to return home and seek help for the cannabis use rather than continue to London. Jack claimed he had stopped smoking cannabis. It does not appear that he disclosed that he had been hearing voices for some time.
11. The assessment concluded that Jack did not need to be detained under the mental health act, nor did he need to be offered a voluntary admission. There was no attempt to make an inter-agency referral to the Birmingham and Solihull Mental Health Foundation Trust (BSMHFT,) instead Jack was encouraged to self-refer. The assessment team recommended that Jack should be picked up by a family member, but '*accepted this may not be possible'*.
12. Jack could now be dealt with for the criminal matters. He was no longer considered to be vulnerable and therefore no appropriate adult was requested for the police interview. He consulted a solicitor at 01:25 on

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[1] **MENTAL HEALTH ACT 1983 SEC 12.(2)** 'Of the medical recommendations given for the purposes of any such application, one shall be given by a practitioner approved for the purposes of this section by the Secretary of State as having special experience in the diagnosis or treatment of mental disorder; and unless that practitioner has previous acquaintance with the patient, the other such recommendation shall, if practicable, be given by a registered medical practitioner who has such previous acquaintance. 'before being transferred to a Mental Health Unit

Sunday 6 July 2014 and was interviewed by officers at 02:12. Prior to this, at 01:20 the investigating officer took out a crime report.

13. This is significant because it is the first stage of a process whereby criminal charges / convictions / cautions are recorded on the Police National Computer (PNC). The PNC is the only national system routinely used by police to discover details of a suspect's offending history when attending an incident. For a record to be created the crime report had to be 'linked' to the PNC.
14. At 02:57 Jack was cautioned for threatening behaviour contrary to section 5 of the Public Order Act 1986 and was released from custody. The force at this time did not carry out pre-release risk assessments.
15. Although Andrew had made numerous attempts to seek information about Jack whilst he was in custody, he was not allowed to communicate with him, and police would not divulge details of Jack's detention.[2] Jack had mental capacity and had not sought to inform either his mother or uncle of what was occurring. Consequently he was handed back his belongings at 02:57 and released. He chose to take a taxi home to Solihull, where it must be assumed he arrived in the early hours of Sunday morning.

3.4.2 The visit to the Walk-In Centre: Sunday 6 July 2014

1. Jack attended a Walk-In centre at 18:13 that day. He was with both his parents. He had apparently become 'very agitated' and was hearing voices and was asking for help. He was seen by a General Practitioner (GP). When the GP asked to speak to him alone, Jack became increasingly agitated and refused.
2. Jack stated that he had been hearing voices for about a week. He had not slept properly for 8 days; sleeping no more than two hours a night. He described himself as generally anxious with a poor appetite. He disclosed

[2] Police and Criminal Evidence Act 1984 – when a person comes into custody they are entitled to certain rights. These are the right to consult with solicitor, right to have somebody informed of their arrest and right to read the Codes of Practice. If detainee (over 18 years of age) does not want anybody informing of their arrest then the custody officer would not divulge information to a third party that would reveal that the detainee was in custody at that time.

occasional use of cannabis. He denied any ideas of self-harm or harming others. Jack wanted *'to stop his mind racing and get better*.'

3. He described being the victim of a racist attack by a gang of youths during which, he was punched in the head. (There is no corroboration for this account.)
4. The Walk- in centre GP diagnosed '*a neurotic condition with insight present, with insomnia.* 'The GP discussed the case with the on-call psychiatrist who suggested prescribing sleeping pills, and advised Jack attends his GP for a referral to the community mental health team.
5. There was no disclosure to the GP of any of the circumstances surrounding his arrest and mental health assessment of the previous day.

3.4.3 The Acute Mental Health Crisis: Monday 7 July 2014

1. Jack's mental health worsened during the rest of the evening. The description of how the tragic events unfolded is taken from the West Midlands Police and West Midlands Ambulance Service Individual Management Reviews. The author has also included the recollections of Julie who in conversation with the chair reflected on how her family reacted to the worsening crisis and how the emergency services responded to the situation unfolding before them and based on the information given to them.
2. Julie recounted that on the Sunday night, her brother was unable to sleep, despite taking two of the sleeping pills prescribed at the walk-in centre. The whole family appears to have been involved in trying to control his behaviour. Julie described her brother's demeanour; '*he looked weird he was just like listening to whatever it was he was hearing. Just listening not talking to anyone. He was staring off into space and unresponsive. He had a look more like he was scared.'*
3. He apparently seemed to feel the need to protect his family from a threat and was insistent that they stayed in the room. He kept saying; *'I need to get a knife, a sharp object.'* On one occasion Jack took hold of scissors, but his mother took them from him. He said he would go to sleep but then took hold of a sharp object (possibly a penknife.)

4. Julie left the room because she '*didn't want to say the wrong thing'* but then her brother asked to speak to her. His words left a deep impression; '*when he spoke to me he got all emotional. Like he knew something would happen, he said I hope you have a better life than me. He said I can hear them they won't protect me.'*
5. Julie remembers her father's response; '*Dad said they are not real. Dad said I can protect you. (He) kept saying that no one was to leave. Stay here where I can see you. If mom got up to leave he said stay. '*
6. As his behaviour became more erratic all three adults tried to control him by pinning him down, but at some point he self-harmed with a penknife. This caused Julie to try and persuade her mother that she needed to call an ambulance. She whispered to her mother what she intended to do and her brother said *'I know I sound mad but I'm not.'* In conversation with the chair she remembered; 'I *said to Mom we need to get him to a doctor. Mom didn't like the thought of the doctors drugging him up. She would try her hardest not to get him to a doctor; she was worried about what they would do to him.'*
7. Julie described how she was feeling in the light of the self-harm and her brother's possession of a knife; '*I felt unsafe but I had never been before. I was worried for everybody. He was aggressive anyway and got into fights. I was worried what he would do with a knife. It was worrying. Sometimes he got into fights at school*.'
8. Julie went into the bathroom and called the emergency services asking for an ambulance at 03:34. The call was around six minutes in duration. The call assessor would be expected to make a decision on whether an emergency responder needed to be sent as soon as possible. This would require the call assessor to relay electronically the key elements of the call to a dispatcher, whilst possibly still talking to the caller.
9. The despatcher would then relay the call over the air and the key elements of the call would be sent to a hand held device known as a Mobile Despatch Terminal (MDT) in the ambulance or emergency responder's vehicle.

Updated information, as the call developed, would more usually be given over the air by the dispatcher, than on the Mobile Despatch Terminal.

10. The call assessor followed the triage questioning protocol to establish that the patient was breathing, to establish the address and phone number of the caller, and the reason for the call. Julie explained; 'He's *mentally unstable. He's paranoid and he thinks that there's something coming out to get us. He really, he always feels he needs a knife to protect himself*.' She explained *'but he's already injured himself twice.'* The call assessor established that one self-inflicted injury was a burn that had occurred the day before, but did not immediately explore the nature of the second injury or when it had occurred.
11. Julie reiterated; *'He's speaking to my parents and he's really unstable. He said if we called the ambulance he would, he would stab himself.'* The call assessor establishes that she was away from her brother who was unaware she was calling but also that her parents told her not to call the ambulance.
12. Julie was asked *"Has he got any weapons?'* and she replied; "*Erm, he's trying to, my mom's got scissors that he, that we've withdrawn from him…but he's trying to get them back, and he's like really, like really my parents are screaming at him now. I don't know what he is going to do. '*
13. Around 2:30 minutes into the call, the assessor alerted the ambulance crew that they needed to attend by switching the log via the despatcher and asked; *'what does he want to do with the scissors?*" Julie replied; *'I don't know. He said he didn't have, he said he didn't want to use them unless he had to but he's so adamant that his delusion is real. He said he will; I don't know he said he wanted to stab you if I called them.'*
14. The call assessor established that Jack had threatened to stab the ambulance crew and then himself.
15. As the call continued, the ambulance despatcher called an ambulance crew at 03:36, referring to the log which was being switched to the crew's Mobile Despatch Terminal; '*it's coming through as a psych patient. Notes just gone on let me have a little look. Brother says he feels like he needs a knife, mentally unstable. If you wanna wait towards scene standby at a safe distance we'll get police. Over.'*

16. At 03:37 the despatcher relayed the message to the police through the Force Contact Centre (FCC) as a call *'for a psychiatric suicide patient'* who had access to weapons; scissors and had threatened to stab ambulance crew and himself. A police log on the OASIS Command and Control system was created and sent to controllers on the Local Policing Unit (LPU)
17. The police emergency call taker asked; *'and the calls come from the patient themselves have they?*' the ambulance despatcher replied "I *presume so I haven't got a caller's name or anything yet it's just a male adult.'*
18. A double-crewed police Taser-equipped unit was despatched. The West Midlands Police Individual Management Review details that a Police National Computer check was conducted based upon details of Jack gleaned from previous OASIS logs. (Author's note: The Police National Computer did not yet show details of the mental health episode and arrest and caution from Saturday 5 July 2014. The Police National Computer entry was not updated until 13:34 on the 7 July 2014 after the homicides had occurred.)
19. The call from Julie was continuing as the two control rooms alerted their crews to the incoming emergency. The call assessor returned to questioning about the condition of the patient, Jack, having established that the incident had calmed outside the bathroom.
20. "*Has your brother been bleeding any red blood very heavily in the last thirty minutes? "* Julie replied; "*Not heavily but he, I think he has been bleeding*.' Over a series of questions the call assessor established that Jack had injured his hand or wrist half an hour before with a penknife causing some slight blood loss and that a plaster had been put on it.
21. At around five minutes into the call, the call assessor addressed Julie's personal safety again; '*Can you hear anything going on downstairs now?* Julie replied that she could hear talking .The call assessor advised' *don't open the door please.'* A few moments later the call assessor asked; *'…Are you safe in the bathroom there are you?'* Julie replied *'I think so'*. The call assessor asked *'OK. And you've locked the door?'* and was told 'I've *locked the door.'* Julie added; *'I'm not sure about my parents though they're still.'* to which the call assessor replied, *'we've organised the police as well alright. We're just*

waiting for the police to come so they can all come in together. OK' .The assessor reassured Julie who reiterated that she would not open the door. The assessor stresses; *' No I was going to say, don't open the door and if you hear anything or he comes to the bathroom or anything like that you call straight back on 999 OK?'*

22. The ambulance responder, the police unit and their respective call centres co-ordinate their rendezvous point. The ambulance responder arrived at 03:41; the police unit was delayed, and timed their arrival at 03:58. The despatcher relayed that a call had been received that a psychiatric suicide patient at address 1 was in possession of scissors and had threatened to stab the ambulance crew and then himself. The ambulance controller also informed the police operator that there was no history on the address at all in their records and that their ambulance crew was on route to attend the address and will wait nearby. Neither the police officers nor the ambulance responder knew Julie was locked in the bathroom, and that a domestic incident had occurred before their arrival.
23. At 04:01, (approximately 20 minutes after Julie's emergency call would have ended) the two crews liaised and the Ambulance responder attempted to gain additional relevant information. The despatcher replied; *"Erm, first note said brother said he feels like he needs a knife to protect the family, mentally unstable. Patient cut himself earlier on a hand/ wrist with a query penknife. Patient behaving like this for a couple of days but acting strange for the last month received?'* The ambulance responder answered; ''*Er, roger. Er as I say we're just with the police just wondering why er we've been called but er we'll go and check over.'*
24. Julie described her mother's response to both the ambulance crew but more particularly the police. She said; *'I said we need to get him to an ambulance but then the police came and she said no. She has a view that they would do bad things to him and treat him bad, like in the movies.'*
25. Julie described her call to the Ambulance service; '*I got through to the ambulance service they said they would be there ASAP. They brought the police too. I stayed locked in the bathroom at first. I heard mom say to him*

(Jack) "the police are here" she said*, "act normal or they will take you away".* In an assessment with a psychiatrist after the homicides, Jack himself said; '*I tried to act rational and calm because I didn't want them to take me away and leave my family.*'

26. The officers approached the house and met Anna who let them in after a brief conversation. Anna disclosed that her son had self-harmed and the two crews saw the wrist injury covered with a plaster. Jack was described by police as quiet and calm, but unresponsive. The Ambulance responder described him as *'on edge and stressed'.* Jack refused physical examination so the ambulance responder had to make a visual assessment.
27. The police officers apparently went to lengths to establish a rapport with Jack. During the course of the conversation with both parents and Jack it was established that John had cancer and was due to have chemotherapy the following day which had caused Jack anxiety.
28. The Ambulance responder tried to persuade Jack to attend hospital, but he refused and the responder deemed he had capacity to make that judgement for himself.
29. One of the officers asked to speak to Anna in the kitchen. She denied he had Attention Deficit Hyperactivity Disorder or mental health concerns, and when asked denied anything had happened with scissors. She described the self-harm injury as being earlier that day and claimed Jack had been treated at the Walk-In centre. Anna was asked who had called and said she did not know, but the officer based upon her replies formed the opinion it was her daughter, who was upstairs. Anna said she was in the bathroom and did not want to come out. At some point Anna disclosed that Jack had had a panic attack on a bus some days before but apparently did not disclose the outcome. (Author's note: It is quite possible Jack had not told her what had happened).
30. The officer in his interview with the West Midlands Police Individual Management Review author stated that he did not inform the ambulance responder that he believed the caller was the daughter upstairs, because he did not want to alert Jack to this fact.

31. In the light of the self-harm concerns, the ambulance responder completed a SADS (SADPERSONS)[3] assessment of Jack, which did not raise concern levels. The responder intended to make a referral to Jack's GP and Jack signed the medical record to acknowledge this.
32. The police officers left the scene at 04:48. The ambulance responder called the ambulance control at 05:03 saying *'Patient did a little bit of self-harm yesterday and mom took him up to the Solihull walk-in centre. Doctor prescribed him Zopiclone. Patient refused observations so I did visuals they were all fine. Patient advised and with police backing and their agreement patient should go to hospital to be assessed, Patient has flat refused due to situation with father wanting to support him However we'll have to inform his GP due to the self-harm to a follow up.'*
33. After the emergency services left, Julie remembers Jack saying he wanted to get something to eat in the kitchen. She heard a commotion and crashing and banging, and again called emergency services from the bathroom at 05:21. She then went downstairs and found her father holding her brother against the wall. She ran to her neighbours for help. At 05:23 reports of stabbings were passed by the neighbour, to Ambulance control and then to police *'teenage male has stabbed mum outside property.'*
34. Police found Anna deceased on the driveway. They forced entry and found John deceased in the living room and Jack with injuries to the neck and body in the kitchen.
35. Jack spent some time in hospital recovering from his injuries before being moved to a secure mental health unit. He was assessed by a psychiatrist who concluded that at the time of the homicides he was suffering serious mental illness; paranoid schizophrenia. The psychiatrist concluded there was clear evidence he was suffering psychotic symptoms for the 48 hours before the homicides. He had reported long-term auditory hallucinations telling him, he and other members of his family would be flayed alive and otherwise tortured. He was suffering therefore, paranoid delusions.

[3] SAD PERSONS is a mnemonic and is a widely used assessment tool for use with suicidal behaviour to assess risk.

36. On the 19 January 2015 he was sentenced to an indefinite hospital order having pleaded guilty to manslaughter on the grounds of diminished responsibility.

3.5 Key themes identified

- **Recognising the onset of an acute psychotic mental health crisis: family and agency responses to Jack's mental health**
- **Custody procedures for vulnerable mentally disordered individuals**
- **Recognising the potential impact of cannabis-induced psychosis**
- **Call-handling procedures between the ambulance and police services**
- **Incident management during the crisis of 7 July 2014**

4. Analysis

1. The tragic events of the 7 July 2014 during which a young man with no established mental health history, fatally stabbed his parents and attempted to end his own life, serves as a stark reminder that both family and friends and health and emergency services need to be alert to the subtle signs of deteriorating mental health.
2. With hindsight it is clear that in the 48 hours before the homicides, Jack was suffering from a serious mental illness; paranoid schizophrenia with paranoid delusions and auditory hallucinations that had been worsening for some weeks.
3. Within that critical 48-hour period, both health professionals and emergency service frontline staff saw Jack. He was subject to a Full Mental Health Act Assessment in custody and within 24 hours, presented to a GP asking for help in relation to auditory hallucinations. Less than an hour before the homicides, he was risk assessed by both police response officers and ambulance personnel in response to a call for help from a family member. The analysis will consider whether there were missed opportunities to identify the nature of the mental health crisis and take action that might have averted this tragedy.

4. Mental Health Act legislation provides powers to detain and treat Jack but based upon what was disclosed or could have been known to professionals, could those powers have been used?
5. Were there police powers that would have allowed Jack to be detained and subjected to a further mental health assessment?
6. The role of Jack's family, who were present during much of that 48 hour period, will be examined to see what part they played and identify the impact of their cultural views and beliefs upon the information they chose to reveal or conceal, from professionals attempting to assess their relative.

4.1 Recognising the onset of an acute psychotic mental health crisis: family and agency responses to Jack's mental health

1. Mental Health professionals (and others) assessing a patient's mental health would ideally seek to gain a detailed and open account of their patient's personal history, establishing any experience of anxiety or depression, drug or alcohol abuse, as well as known mental health concerns in the family. The symptoms of mental health deterioration would be gathered ideally from observations of the patient, eye witness accounts, the patient's disclosures and often from family and friends who identify changes in behaviour.
2. The facts identified in this review suggest that observations of Jack could be misleading. The police officers arresting him from the side of the motorway on the 5 July 2014, described him as calm and compliant. From their viewpoint he had no mental health issues. (These were only identified when he admitted to hearing voices upon entering custody and by his attempted self-harming thereafter.)
3. During the subsequent mental health assessment Jack made '*good eye contact'* and interacted in a way that led professionals to believe that the episode had been a cannabis-induced psychosis that had passed.
4. At the Walk-In Centre on the 6 July 2014 Jack became 'agitated' but was considered to be suffering from a neurotic condition with insomnia.
5. When the ambulance responder was faced with Jack in the middle of the most acute phase of his psychotic state, he concluded he was '*on edge'*.

6. During each of these contacts with professionals, Jack was not identified as a paranoid schizophrenic in acute crisis, which with hindsight was clearly the case. He was apparently able to supress or manage his behaviour whilst suffering psychotic delusions and auditory hallucinations.
7. The importance, therefore of Jack being prepared to describe to professionals what he had been feeling and experiencing, cannot be overstated. In addition, the willingness, or otherwise, of his family to be open and honest about what they had seen, heard and experienced would be a factor influencing the pathways to mental health care for Jack.
8. Jack, whilst apparently wanting to stop his auditory hallucinations did not appear to have understood their mental health implications or have reached a point where he would describe the impact his mental health was having upon his life. His sister told the chair that he thought he was *'OK'.*
9. The reason for this appeared to be a combination of interrelated factors; the family dynamic and relationships, Jack's character, as well as attitudinal and cultural beliefs of Anna. Only Julie had a realistic view of the mental health crisis and due to circumstances and missed opportunities, she was never given the chance to intervene.
10. It is clear that Jack's personal life had reached a crisis by July 2014. He was unemployed and had failed to complete his degree course. He had incurred significant debts. By his own admission, he had both a drink and drugs problem during his time at university. He told a psychiatrist during a pre-trial assessment that during that period he used £20 of cannabis every three days as well as 'dabbling' with the stimulant mephedrone (MKat,) the psychoactive drug MDMA (commonly known as ecstasy) and cocaine on an infrequent basis. In the weeks leading up to July 2014 Jack was according to his sister, using a lot of cannabis. The behaviour changes and signs of mental health deterioration were very evident to Julie, and must also have been to their parents.
11. Yet the crisis in Jack's life that very probably contributed to his cannabis abuse and mental health crisis could not be discussed with his parents. Only Julie, within the immediate family, had the kind of relationship with her

brother where troubles would be shared, and it was a symptom of the mental health crisis, that as it deepened, his relationship with his sister deteriorated.

12. Andrew described Jack as proud and unlikely to seek help with his financial or personal problems; '*he would normally talk to me about things but he would also want to take the responsibility by himself. I think that is why I did not know about his mental health issues. When he was living away he could not afford the rent but he never asked me for help.'*
13. The panel were provided with information that showed how Solihull Integrated Addiction Services (SIAS) publicise pathways into mental health services in the borough. Although the well-designed and informative website may well have suited Jack, had he accessed it, it seemed that in this case, he only made very tentative first steps to seek help in the days immediately before the homicides.
14. Although advised to seek support for cannabis-induced psychosis after the mental health assessment in custody, Jack's subsequent presentation at a Walk-In centre suggested he was not ready to openly address any mental health concern he may have had. The inhibiting factor may well have been the presence of Anna and John.
15. Anna had had relatively recent experience with a mental health crisis suffered by her other son, David. It seems unlikely from what is known that she would have seen the experience as positive. Professionals identified her as being hostile to anti-psychotic medication (which actually helped David and probably could have helped Jack.) Her relationship with her son David broke down completely during the period he was engaged with the Early Detection and Intervention Team. It is reasonable to assume that Anna's distrustful attitude to mental health services became entrenched due to this experience.
16. Julie was clear that her mother had a poor image of mental health services. She explained; '*She did not like doctors or mental health services. If I was ill it was ok to go to the doctors, but if it was for mental health she did not like*

that. I did try and tell her but she said they will hurt him. She was the same with (David). She said they would take him away and do things to him.'

17. The review panel was aware of the cultural attitudes towards mental health sometimes identified in some South East Asian communities. These range from denial, to a sense of shame and dishonour, where mental health is present. Amongst those South East Asian communities firmly established within the UK, it is possible that first generation immigrants may still hold some of these attitudes. Julie was clear in conversation that young adult south-east Asians born in the UK, generally have more informed attitudes to mental health.
18. The chair asked Julie to what degree she believed cultural attitudes and the views of her south-east Asian family and community, would have affected her mother's view of mental health and treatment. She considered that,' *her view was based on what she saw in the movies. She was quite fictional in her thoughts… Mom and dad were isolated from the Chinese community and would not socialise with others. That was not what was influencing her. Growing up watching things, mom was impressionable, it was deep rooted. A bit like that she grew up thinking bad things would happen.'*
19. It is the view of the panel that Julie may not have had a clear appreciation of the influence of her mother's Vietnamese upbringing and refugee status as a child, possibly had upon her views of authority figures like police and even doctors. However the Domestic Homicide Review in the absence of any other direct evidence would not want to overstate their significance.
20. There has been considerable work done to change the public's perception of mental health. The Mental Health charity Mind, and 'Time to Change' a mental health anti-stigma programme funded by the Department of Health, Comic Relief and the Lottery Fund pointed to the findings of an annual survey conducted by the Institute of Psychiatry, King's College, London.[4]
21. The most recent data shows that since the beginning of the current programme of Time to Change (2011) *an 'estimated two million people – or*

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[4] Attitudes to Mental Illness 2013 Research Report. Prepared for Time to Change Feb 2014

4.8% of the population - have improved attitudes towards people with a mental illness. It also shows that there was a 2.8% improvement in attitudes between 2012 and 2013 – the biggest annual shift in the last decade. While direct comparisons can't be made before 2003, it also likely that this is the biggest annual improvement since the first survey was commissioned 20 years ago.' However the report did identify that white respondents showed more positive attitudes to mental illness than those from black and minority ethnic groups.

22. The Domestic Homicide Review has not been presented any evidence in the Individual Management Reviews submitted that cultural beliefs about the causes of mental health were addressed with Jack during his mental health assessment in custody on the 5 July 2014 or with his parents when he visited the Walk-In Centre on the 6 July 2014.
23. Guidelines [5] issued for treatment of patients suffering psychosis or schizophrenia consider race, culture and ethnicity and suggest practitioners need to be competent in;

- *assessment skills for people from diverse cultural and ethnic backgrounds*
- *using explanatory models of illness for people from diverse ethnic and cultural backgrounds*
- *addressing cultural and ethnic differences in treatment expectations and adherence*
- *addressing cultural and ethnic differences in beliefs regarding biological, social and family influences on the causes of abnormal mental state*
- It is possible that had the stigma of mental health been addressed with Jack and the impact of cultural attitudes been acknowledged with his parents, Jack (and his parents) may have been more open with professionals.

[5] Psychosis and schizophrenia in adults: treatment and management Issued: February 2014 last modified: March 2014 NICE clinical guideline 178 recommendation 1.1.2.2.

4.1.1 What do we learn from agency and family responses about recognising an acute psychotic mental health episode?

- Practitioners should address cultural attitudes to mental health where appropriate during assessments to identify early on any inhibitions or concerns that could hamper effective care
- Although attitudes to mental health in the general population have changed markedly, practitioners need to be alert to the possibility that some patients may still choose to disguise symptoms and concerns. Their families may collude in this, for reasons which may be cultural, or personally held misconceptions
- Multi-lingual leaflets should be available to patients and carers which address commonly held misconceptions about mental health and challenge cultural attitudes rooted in notions of shame or honour

4.2 Custody procedures for vulnerable mentally disordered individuals

1. Upon arrival into custody following his arrest on Saturday 5 July 2014, Jack claimed not to have mental health problems but described hearing voices in his head. He did however disclose minor self-harm when he was 14-15 years old. (Author's note: This had also been disclosed when he was in custody in 2008 but the custody officer had failed to place a marker on the Police National Computer.) It was the subsequent attempt at self-harm in custody in Hertfordshire that led to constant observations being placed and accelerated the need for a mental health assessment.
2. The arresting officers had not actively considered his mental health, because he presented in a calm compliant way. From within the party travelling with Jack, they had only spoken with Anna, who was distressed to see her son taken by police. She would not have understood that custody could provide a pathway into mental health care for her son. In any case, she apparently

would not have seen this as a positive outcome, because of her views on mental health and indeed the police.

3. Julie may have been more forthcoming in describing concerns about her brother, but she remained on the coach and the opportunity was missed. The family left and this potential source of background information was lost whilst Jack was in custody.
4. During the full mental health assessment Jack said that his mother apparently felt he needed mental health help (in part because of David's mental health problems). However there does not appear to have been any attempt to seek Jack's permission to speak to his mother before the assessment. When the assessment concluded that Jack did not need to be detained for mental health treatment, Jack specifically asked the Approved Mental Health Professional not to tell Anna. It is possible that there was a missed opportunity to contact Anna before the assessment (albeit the findings of the review would indicate she was unlikely to be very forthcoming).
5. National Institute of Clinical Excellence (NICE) recommendations[6] stress the importance of involving carers in the assessment of a patient exhibiting psychosis;
6. *'Carers, relatives and friends of people with psychosis and schizophrenia are important both in the process of assessment and engagement, and in the long-term successful delivery of effective treatments. This guideline uses the term 'carer' to apply to everyone who has regular close contact with people with psychosis and schizophrenia, including advocates, friends or family members, although some family members may choose not to be carers.'*
7. Whilst the review recognises that the Full Mental Health Act Assessment concluded that Jack had suffered cannabis-induced psychosis that had passed, it could be argued that had they obtained a fuller picture they may

[6] **Psychosis and schizophrenia in adults: treatment and management Issued: February 2014 last modified: March 2014 NICE clinical guideline 178 guidance.nice.org.uk/cg178**

have been more reluctant to conclude that this was entirely drug-induced psychosis and that all risk had also passed.

8. Under the Police and Criminal Evidence Act 1986 (PACE), a custody officer must call an appropriate adult (AA)[7] **immediately** if they have any suspicion, or are told in good faith, that a person has a mental disorder or mental vulnerability. 'Mentally vulnerable' includes anyone who, because of their mental state or capacity, may not understand the significance of what is said, of questions or of their replies. This includes people with mental illness, learning disabilities, Attention Deficit Hyperactivity Disorder and autistic spectrum disorders. If there is in any doubt about a person's mental state or capacity, PACE states an appropriate adult is required for police procedures such as explanation of the prisoner's rights, identification, searches and interviews.
9. In this case, the custody sergeant stated he believed Jack did understand the procedures and entitlements. He went further and argued that he did not fit the definition of a vulnerable adult. He simply felt he might not be '*right*'. His capacity to understand was not however the sole criteria for requiring an appropriate adult. There was clearly doubt about his mental state and this should have triggered the call for an appropriate adult. However apart from the booking in process, no police procedures were conducted for the first fifteen and a half hours of Jack's detention. The presence of an appropriate adult during this period would not have greatly assisted.
10. The custody sergeant chose to wait until Mental Health screening by the custody nurse was completed. The custody nurse could undertake the initial mental health assessment to determine whether Jack was fit to be detained, interviewed or charged.
11. The Force Medical Examiner agreed with the nurse that Jack could be detained but was not fit to be interviewed or charged and stated that an appropriate adult should be called.

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[7] An appropriate adult can be a parent or other family member, friend or carer, social worker (or mental health worker), charity worker, specialist appropriate adult either paid or voluntary

12. The intention to carry out a full mental health assessment persuaded the custody sergeant that he would wait for the conclusions of that assessment by the Approved Mental Health Professional and section 12 Mental Health Act doctors. They would advise on whether Jack had a mental illness, or disorder and whether he could be subject to interview and charge. They would also alert the custody sergeant to the need for an appropriate adult for those police procedures.
13. PACE Codes of Practice[8] amended in May 2014 now state in relation to mental health assessments in custody;' *the appropriate adult has no role in the assessment process and their presence is not required*. '
14. When the assessment concluded that the police process could continue because Jack's cannabis induced psychosis had passed, the Hertfordshire Constabulary Individual Management Review identified that the custody sergeant should have asked the team to formally record their finding and also confirm an appropriate adult was no longer required. That this did not happen did not apparently lead to any identifiable detriment to Jack. He had a solicitor present who apparently had no on-going concerns about his mental health.
15. The panel have been informed by Hertfordshire Constabulary that following a fast time internal review, conducted by an Assistant Chief Constable, a decision was made and passed to custody staff on the 8 July 2014 that; '*an appropriate adult is needed in all cases where the detainee's vulnerability is evident. Such cases will always include where the detainee` has been subject to a mental health assessment that results in fitness to detain and interview*.' The panel considered the review to be good practice, and the changes made are a useful additional guarantee of a detainee's rights and wellbeing. (Although the presence of an appropriate adult was not required under the

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[8] REVISED CODE OF PRACTICE FOR THE DETENTION, TREATMENT AND QUESTIONING OF PERSONS BY POLICE OFFICERS POLICE AND CRIMINAL EVIDENCE ACT 1984 (PACE) – CODE C paragraph 3.16

Police and Criminal Evidence Act, it may have helped to support and reassure Jack.)

16. It could also be argued that, with greater awareness of mental health, or a formalised mental health screening process, the custody sergeant could have identified Jack's mental state far more quickly. It took over twelve hours to reach the stage where Jack had been subject to a full mental health assessment, and seventeen hours before he was released.
17. Since April 2015 Health Care Professionals have been imbedded within Hertfordshire custody units. This according to Hertfordshire's submission to the review apparently allows for much swifter assessments of detainees for physical and mental health issues and could lead to an earlier section 12 assessment. (Author's note: A nurse was available on the evening in question and served only to confirm the view of the custody sergeant that a section 12 review was required.)
18. The panel felt that notwithstanding this improvement, the screening questions on arrival in custody are insufficient; making it less likely mental health concerns will be identified promptly. Studies and practical trials have been conducted on more targeted screening processes.
19. The Offender Health Research Network (OHRN) is a multi-disciplinary, multi-agency network focussed on offender health care innovation, evaluation and knowledge dissemination, funded by the Department of Health. In 2013 together with academics from Manchester University, the Lancashire Care NHS Foundation Trust and Lancashire Constabulary, they developed a fourteen-question screening tool (POLQUEST) to be used by custody sergeants to accurately identify the need to refer to mental health professionals.[9]
20. The POLQUEST contained fourteen screening questions, some of which were recognised as 'high risk'. If these were answered in the affirmative, it would prompt the custody team to make an immediate referral to Mental Health services whilst the subject was still in custody.

[9] OHRN. Manual for the Police Mental Health Screening Questionnaire (PolQuest) and Referral Pathway (Sept 2013)

21. Historical self-harm and a present desire to self-harm represented such triggers. Other 'red' triggers are affirmative responses to *'Have you recently felt that your thoughts have been directly interfered with, or controlled by another, in a way that people would find hard to believe?'* and also *"Have you recently heard voices when there was no one around to account for this?"*
22. It is argued that the custody sergeant could have reached the required intervention by mental health professionals far sooner had better screening questions identified the signs and significance of delusions / hallucinations and the associated heightened risk from self-harm.
23. Hertfordshire Constabulary have brought in a "Vulnerability Assessment Framework" (VAF) designed to manage the risk and vulnerability of a detainee that includes an assessment form completed by the officers bringing a detainee into custody. This together with the appropriate adult guidance will improve mental health screening. However the force has agreed to consider POLQUEST or a similar tool to enhance mental health screening.
24. As a result of a review conducted by Lord Bradley in 2009, all forces have a commitment to 'diversion at point of arrest' schemes.[10] Progress towards these schemes is very different from force to force. Mental health diversion schemes operate at the interface between criminal justice and mental health. They seek to ensure that people with mental health problems who come into contact with the police and courts are identified and directed towards appropriate mental health care, particularly as an alternative to imprisonment. Had this scheme been operating in Hertfordshire, it is likely that this would have led to a mental health referral following the completion of the custody procedures. The panel were informed that a Diversion Scheme is planned for Hertfordshire Constabulary however it is unlikely to be in place before 2020.

[10] The Bradley Report Lord Bradley's review of people with mental health problems or learning disabilities in the criminal justice system April 2009

25. Although West Midlands Police were not responsible for custody issues in this case, their view was that within their custody centres they are achieving best practice in relation to detainees with mental health concerns. Liaison and Diversion Teams are now based in three custody blocks. They provide a team of mental health nurses and social workers covering 08:00 x22:00 hours, seven days a week, able to provide a diversion process for all age of detainees who present with mental health vulnerability. In July 2016, in line with the reorganisation of West Midlands Police Criminal Justice, the Liaison and Diversion teams will be located in all custody blocks across West Midlands Police.
26. Jack was released by the night duty custody sergeant on the basis that there was no longer a risk of harm to himself or others. Despite the recommendation that he be released to the care of a family member, no attempt was made to secure this. It does not appear that a referral to Solihull Mental Health Services was ever sent through. Whilst in this case it could not have had a positive impact because of timescales involved, it seems reasonable to expect that where police become aware of a mentally vulnerable individual in custody because they attempted self-harm, they should seek to alert that detainee's local mental health team to their vulnerability. Hertfordshire Constabulary have identified their health care professionals as responsible for completing this role.
27. The broader requirement placed upon Local Authorities by the Care Act 2014, to assess whether adults need care and support would appear to have relevance in Jack's case. His possible cannabis addiction, and potential mental health vulnerability indicated that he had unmet support needs. It was the panel's view that the issue of appropriate referrals to relevant adult services, alerting them to the care and support needs of an adult in custody, is one which needs to be reviewed by police services when commissioning custody healthcare.
28. The necessary referrals should be part of a pre-release risk assessment, which takes into account identifying the family and carers of a vulnerable

detainee. This would provide a strengths-based consideration of a person's care needs once the police service are no longer responsible for their care.

29. The Hertfordshire Police Individual Management Review explained that following the fast time internal review led by the Assistant Chief Constable, a decision was made to immediately introduce pre-release risk assessments.
30. A direction was sent to custody staff on the 7 July 2014, instructing them to complete pre-release assessments on the release of a vulnerable adult from custody. The guidance was reinforced by the requirement that '*such cases will always include where the detainee has been subject to a mental health assessment that results in fitness to detain and interview.*' The review panel consider this to be very good practice.
31. The risk assessments record details of the medical treatment received, the means of transport home after release from custody, any advice given relating to contacting their GP, referrals to agencies, family or friends with consent. The assessments have been revised since their first introduction to provide a broader identification of vulnerability.
32. It is the panels' view that self-harm in custody should raise the risk level in the pre-release assessments to high or very high. Where the Custody Officer believes that the person may be an immediate danger to themselves or others, then a referral should be made on that persons behalf, preferably with their consent, but, if necessary, without it.
33. Whilst the custody sergeant releasing Jack had been told that the self-harm and auditory hallucinations had been the result of a cannabis-induced psychosis that had passed, it is clear with hindsight that the danger to Jack and others had not.
34. Whilst the review agrees with the Hertfordshire Constabulary Individual Management Review's conclusion that had a pre-release risk assessment been undertaken it would not have altered events, this is because there is not sufficient weight placed upon self-harm in custody even under the new pre-release assessment.
35. It is possible that more focus on where the detainee went upon release may have led to Andrew being asked to meet Jack. Hertfordshire Constabulary

have now produced a policy regarding the use of two locally approved taxi firms for vulnerable detainees. However there is a stipulation that the family or friends of the detainee should be considered first. Had this policy existed at the time, Andrew may have been called upon to provide transport to a suitable address. It is of course unclear whether Jack's acute phase would have played out in a different location with potentially similar tragic results.

4.2.1 What do we learn about custody procedures for mentally vulnerable individuals?

- The early identification of a detainee's mental vulnerability may not be achieved with current triage questions. The use of a more detailed mental health screening tool on arrival into custody (such as PolQuest) should be explored by police services
- Mental health assessments in custody should draw on information from family and carers. Unwillingness to allow engagement with or disclosure to family by a detainee should be seen as a warning sign where the detainee is to be released to that address and their support will be important to the detainee
- Whilst a custody mental health assessment may conclude that a detainee is fit to be detained, interviewed and charged and are not mentally disordered, the behaviour which caused concern (self-harm, psychotic behaviour) means that they were mentally vulnerable and probably remain so. Where symptoms have passed, mental health referrals should be encouraged and the detainee's consent sought as part of the release process. Encouraging self- referral and signposting that person may not always be sufficient.
- Pre-release risk assessments should be reviewed and a mental health referral should be made (with or without consent) if a detainee self-harmed in custody
- Police services should consider in the light of the Care Act 2014 section 9, the duty of local authorities to provide care and support needs assessments Where it is believed a detainee has such care and support needs, police services should identify with custody healthcare commissioners how, (with the consent of the detainee), such referrals should be made. (Recommendation 6)
- Where a detainee is mentally vulnerable and may need an appropriate adult, custody officers should always be made aware of family members contacting the force control room or the station, seeking to support that detainee
- All officers need to be reminded of the importance of prompt entry of charges/cautions on Police National Computer. Forces should ensure their

procedures are robust and fit for purpose

4.3 Recognising cannabis-induced psychosis and its' long term impact upon mental health

1. The full mental health assessment conducted whilst Jack was in custody concluded that he had experienced a drug induced psychotic episode that had now passed.
2. Advice provided by the Royal College of Psychiatrists [11] suggests that; *'some people may develop temporary psychotic symptoms, such as hallucinations and delusions, which resolve themselves within hours or a few days without help*.' It was therefore not unreasonable, based upon Jack's demeanour and selective disclosure, that this episode could have been characterised as one that did not require psychiatric services.
3. However there seems to have been an assumption by the professionals that without further consumption of cannabis, symptoms would not reoccur. Underlying the suggestion that Jack seek help from his GP for cannabis use is the implicit belief that this was not an episode that indicated worsening mental health. In a recent article, a psychiatric consultant from the Shropshire Community & Mental Health Services NHS Trust pointed out[12]; '*there is a slow and gradual effect of cannabis and the symptoms continue to worsen for some time after the person stops using it.'*
4. It appears possible that Jack's deterioration after release from custody was still attributable to cannabis–induced psychosis, although the assessments of Jack in custody after the homicides do not attribute the psychosis to cannabis.
5. Cannabis-induced psychosis and schizophrenia have many shared elements. Schizophrenia has negative symptoms; a withdrawal or lack of function, not wanting to leave the house, not wanting to engage with family or friends,

[11] Royal College of Psychiatrists "Cannabis and Mental health'

[12] Dr. Brian Boettcher Cannabis Psychosis.(Priory Lodge education)

apathy, sleeplessness. It also has positive symptoms; hallucinations and delusions. With hindsight we know that Jack was exhibiting all of these symptoms in the days leading to his acute mental illness.

6. There is no indication that the assessment offered the alternative possible conclusion-that there could be comorbidity; paranoid schizophrenia present that was worsened by the consumption of cannabis. Jack informed the Approved Mental Health Professional during the assessment that his brother had suffered a mental health breakdown but it is not clear what impact this had upon the assessment. It is well established that mental health problems can run in a family and be related to genetics but it can also have other explanations. Without seeking more information it does seem that the reliance on a diagnosis of cannabis-induced psychosis is at least debatable.
7. The mental health assessment seems to the review panel not to have taken the episode of psychosis sufficiently seriously. Cannabis-induced psychosis can lead to very serious long-term mental health implications. A recent British Journal of Psychiatry study[13] concluded; '*our study shows that cannabis-induced psychotic symptoms are an important risk factor for subsequent developments of severe psychopathological disorder. This is in contrast to previous studies describing the condition as harmless. Although it cannot be determined that cannabis has a causal impact on the subsequent development, the findings have clear implications for clinicians who encounter a patient with cannabis-induced psychotic disorder. The prognosis is poor and attention needs to be given to early intervention.*'
8. Jack was suffering depression and stress caused by his financial situation and lack of employment, which may have led him to 'self-medicate' with cannabis. If his underlying problems were not addressed it was unlikely that he would simply stop using the drug.
9. The review has no direct evidence as to whether Jack used cannabis following his release and before the homicides. Given that a little more than 24 hours

[13] Cannabis-induced psychosis and subsequent schizophrenia-spectrum disorders: follow-up study of 535 incident cases. Arendt, Rosenberg, Foldager,Perto, Munk-Jorgensen BJ Psych 187 p 510- 515.(Feb 2013)

later, Jack was suffering a serious mental illness with further clear psychotic symptoms it is quite possible. Whether or not it was worsened by cannabis, Jack was showing acute psychotic symptoms at the time of the homicides.

10. The panel concluded that cannabis- induced psychosis is a public health issue requiring greater public awareness. Young people should be made aware of the mental health risks associated with cannabis use. Many studies have pointed to the danger of allowing cannabis to be characterised as a 'soft' drug. The apparently harmful impact upon Jack's mental health of cannabis use does seem clear, whether or not there was an existing mental health problem.
11. The panel were provided with details of local measures already in place to raise the awareness of the impact of substance abuse upon mental health. Solihull Integrated Addiction Services promote pathways to support aimed at young adults in the borough.
12. NHS Choices in February 2015 published details of a new study into the impact of 'super strong' skunk cannabis upon psychosis.[14]
13. It was the panel's view that the tragic outcome in this Domestic Homicide Review and growing evidence from academic research, justified consideration of a national awareness raising campaign. (**Recommendation seven**)

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[14] **Proportion of patients in south London with first-episode psychosis attributable to use of high potency cannabis: a case-control study** Marta Di Forti, Arianna Marconi, Elena Carra, Sara Fraietta, Antonella Trotta, Matteo Bonomo, Francesca Bianconi, Poonam Gardner-Sood, Jennifer O'Connor, Manuela Russo, Simona A Stilo, Tiago Reis Marques, Valeria Mondelli, Paola Dazzan, Carmine Pariante, Anthony S David, Fiona Gaughran, Zerrin Atakan, Conrad Iyegbe, John Powell, Craig Morgan, Michael Lynskey, Robin M Murray **Lancet Psychiatry**

4.3.1 What do we learn about recognising the potential significance of cannabis-induced psychosis?
• There appeared to be some minimisation of the dangers from cannabis-induced psychosis which did not seem to take into account that it had been accompanied by recent self-harm • The assessment that the mental disorder had passed after a period in detention did not appear to take into account that in the case of cannabis-induced psychosis, symptoms can worsen even without further drug use • There is a public health issue that needs to be addressed to ensure that young people and families are aware of the potential of serious mental illness as a consequence of cannabis use. **(Recommendation seven)**

4.4 Call-handling procedures between West Midlands Ambulance and Police Services

14. Details of the calls made by Julie in the early hours of Monday 7 July 2014 have been included in detail in section 3.4.3 because with hindsight it is clear that she had real concerns for the safety of herself, her parents and her brother.
15. The review panel noted that given Jack was in possession of a sharp instrument, the call Julie made could just as easily been routed to the police as a disorder, rather than to the ambulance service, because Jack was mentally vulnerable.
16. This incident illustrated the vital importance of ensuring that all relevant information was identified by the ambulance call assessor and passed to the responder via a call handler, using the combination of radio transmissions and messaging on a Mobile Despatch Terminal (MDT). The Ambulance service needed to identify the reason for requiring police attendance and share it with the police call centre.
17. It is clear that the emergency services need to be able to prioritise urgent calls. For that reason a call assessor is assisted by a despatcher, so that responders can be sent on their way and updated en-route as the call

assessor obtains more information from the caller. These processes are mirrored in both the ambulance and police services.

18. It was tentatively suggested to the panel that the priority for an ambulance call assessor is identifying potential life threatening medical emergencies, and the triage questions are directed to this end. Identifying safety concerns for the caller would not be an immediate priority in the same way as it might if the call assessor were from the police service.
19. The Ambulance service Individual Management Review concluded that Julie was in the bathroom to prevent her brother finding out she had called, rather than for reasons of personal safety. It was suggested at panel that on the recording of the call, Julie sounded calm throughout which may have allayed the call assessor's anxiety. If that is true, it shows a preconceived view of how a caller should sound, when fearful. It is to be hoped that the service now recognises this and trains its' call handlers, learning from this experience.
20. What is evident from the transcript alone, is that by the end of the call from Julie, the call assessor was sufficiently concerned for Julie's safety that she asked several times whether the bathroom was secure and told Julie to remain there until ambulance and police arrived.
21. Julie was categorical when she spoke to the author; she feared that her brother would kill them all. She did not use those words to the call-assessor.
22. However the call assessor was given sufficient information to consider this to be a high-risk call. Julie said Jack was mentally unstable, paranoid and believed that he needed a knife to protect himself or the family. He had self-harmed with a knife that night, as well as self-harming by burning. He had struggled with his family who had tried to disarm him. A noisy argument and possibly a struggle involving the patient had occurred whilst the call was in progress, as he tried to recover the weapon. The caller was locked in the bathroom making the call although others on scene did not want her to make it. The caller stated that if ambulance services attended he intended to stab them and then himself. All of these elements raised the risk for professionals attending and persons present to a potentially high level.

23. The Ambulance service identified in its Individual Management Review and at panel, that the Mobile Despatch Terminal could only display a certain number of words on screen. These would generally be taken up with pertinent medical information. The panel recognised the Mobile Despatch Terminal may have capacity issues that need to be addressed. However the process always involves radio messages. There was no reason that the call assessors' computer aided despatch log could not contain sufficient for the despatcher to be able to recognise the obvious risk to the responder, the caller and her family. It appears that whilst the ambulance service correctly identified the threat to their crew, and called for police assistance, they did not explicitly record or 'flag-up' the threat to the family.
24. What seems clear is that neither the ambulance responder nor the police officers attending ever had a clear understanding of the known and identified risk factors which had been established by the call assessor by the end of the first call made by Julie.
25. The ambulance responder asked the despatch immediately before going into the house why ambulance services had been called. Even at this point, (some 20 minutes after the call had ended) the handler seemed unable to give a clear and concise summary of the nature of the call, the source of the information (Julie,) and a clear indication of why police were required. The Computer Aided Despatch system notes available to the handler should have contained a clear summary of all identified risk. It should have required the responder to brief the police that the safety of the entire family but particularly the caller needed to be ascertained immediately upon entry.
26. It is a concern to the review panel that the call routing process, which is repeated in emergency service call centres hundreds of times in every day, could allow so much scope for miscommunication. It is reasonable to assume that similar communication difficulties could be occurring on a daily basis.
27. The failure to identify key elements of risk and pass them to responders was described at panel by a West Midlands Ambulance Service manager as an error made by the call assessor. The review has not been provided with details of the level of experience or training of the call assessor, or any other

relevant factors that could account for the apparent failure. The panel would therefore seek assurances from West Midlands Ambulance Service that training and processes are now in place reducing the risk of similar errors in future, and that supervisors could identify such errors before they had a detrimental impact upon patient safety. **(Recommendation four)**

28. The Police call handlers were not given vital relevant information from West Midlands Ambulance Service control room that may have influenced the actions of their responders. The service informed the panel of planned improvements to call handling that would also impact upon calls received from other emergency services.
29. '*From April 2016 all Force Contact Centre staff will have received training in the new THRIVE+ risk assessment model, which will be utilised when dealing with 999 calls (this includes calls from other emergency services to West Midlands Police.) The Thrive+ risk assessment will also be incorporated within the OASIS logs where assessment is required for the grading of the response. Any changes to the risk management of an incident will require further explanation of the down/up grading of that incident. This is clearly visible to supervisory staff within both the Force Contact Centre and Local Contact Centre. Grading of response will also be changing and instead of Immediate, Early, Routine will be P1 – P9. The reason for this will ensure that logs are correctly supervised and that when an attendance is required it will be flagged to the supervisor that a response is required/not met. West Midlands Police call operators as part of the Thrive+ assessment will ask more in-depth and reaching questions to establish and manage the risk, these questions will be routinely asked during the passing of an incident from West Midlands Ambulance Service to West Midlands Police. Learning from all reviews, Domestic Homicide Reviews, Serious Case Reviews and Serious Adult Reviews, are now routinely embedded across all aspects of training for all West Midlands Police employees.*'
30. It would appear to the Chair that West Midlands Police are already putting in place increasingly refined processes which identify dynamic risk in calls received by the service.

4.4.1 What do we learn about the call handling procedures between West Midlands Ambulance Service and West Midlands Police?
• Communications between the two services must be concise, professional and clear and assumptions should not be made concerning the nature of the call or the identity of the caller. • Call handlers should refer back to the Computer Aided Dispatch/OASIS log after a call is concluded or a call assessor judges that all relevant information has been obtained, to ensure information passed to their responders remains relevant and accurate • The Computer Aided Dispatch notes of a call to ambulance service should be adapted to allow identification of safeguarding risks to the caller or others (as well as professionals) which should be ' flagged ' • The protocols for ensuring that the relevant risk information is passed to responders should be reviewed to ensure that call assessors and despatchers work more effectively together • Flagged risk indicators should be reviewed by a call centre supervisor to ensure risk was addressed before a log is closed • The Manual Despatch Terminal used by the ambulance service should be reviewed to ensure that it is capable of providing a responder with both key medical but also critical safety information • Training of call assessors should challenge assumptions arrived at from the tone and emotion of the caller • Call handling between services could be simplified with shared Contact Centres

4.5 Incident management during the Acute mental health crisis of 7 July 2014

1. The call made by Julie was to ambulance services and was an ambulance service led incident even though a safety risk had been identified.
2. Had the Police National Computer entry of Jack's arrest and caution for threatening behaviour less than two days before been entered on the system in a timely manner officers would have noted that mental health and the use of sharp instruments was a feature of Jack's recent behaviour. Regrettably

due to individual error, it was not updated until the afternoon of 7th July, some hours after the homicides and attempted suicide. Similarly, Anna described the incident that led to Jack being cautioned, as a panic attack on a bus but did not mention the involvement of police and subsequent arrest. It is quite probable that none of the family knew how the matter concluded.

3. Police were called and Taser-equipped officers were sent to the scene because of the risk of harm to the ambulance crew. But because the ambulance despatchers never properly articulated the nature of the threat, once Anna denied there had been an incident, or that Jack had been holding a sharp instrument and had self-harmed, the absolute requirement for police attendance had seemingly ended. Officers remained to back-up the single crewed ambulance responder.
4. When police are called to a disturbance there would be an expectation that the caller would be found, identified and their safety established. Particularly where a domestic abuse incident has been alleged, police should never leave a scene without identifying everyone concerned.
5. Unfortunately ambulance control never informed their responder or police that there had been sounds of a domestic dispute whilst the caller was on line. This made it easier for Anna to convince the officers and ambulance responder that nothing untoward had occurred. She covered up the recent self-harm by saying it was not recent and had already been seen by a GP. In playing down the immediate risk, she diverted attention away from Jack who played his part as directed by his mother, by being calm and compliant.
6. It is of particular concern that the safety of the caller was never established, by either police or the ambulance responder. In the first instance the ambulance control room should have alerted the crews to her presence in the bathroom since she had been told to stay there and wait for the emergency services.
7. When one police officer made the assumption Julie was the caller and that she was upstairs, the officer neither told his colleague nor informed the ambulance responder. In hindsight the officer explained this was to ensure Jack did not identify the call maker. Maybe because the potential gravity of

the incident had never been clear, both the officers and the ambulance responder scaled the response down. The police did not revert to what would be the default position of police attendance at an incident; locate the informant.

8. The tragedy in this case is that Julie could hear what was being said, and was expecting officers to come and speak to her. Conscious that she would be going against the wishes of her mother, she did not present herself but was clear in conversation with the author that she would have spoken out despite her mother's veto; ' *I could hear what they were saying I stayed upstairs. I came out of the bathroom. I then felt safe but stayed upstairs. I did expect that they might come to speak to me. I thought they would have come to speak to me. I would have said the same to them as I am telling you. I would have told the services I thought he would kill us all. I would not lie. I didn't care what he thought I wanted (him) to get better I wanted to go to sleep. I would have told them. They didn't tell (him) who had called them. They didn't ask for me. They knew someone in the house had called them. Even then, when they were there, what he was saying was weird.* '
9. Police presence at the scene was to prevent a risk of harm to anyone present. They are limited to using arrest powers for criminal offences or breach of the peace.
10. However had Julie revealed the mental health arrest, the domestic disturbance that had just occurred, the recent self-harming with a knife, the struggle to disarm Jack, her fear that he would rearm himself and kill them all, the panel has no doubt that Jack would have been arrested to prevent a breach of the peace and taken into custody, where a further mental health assessment would have been undertaken.
11. This was the only way by which police could have legitimately removed Jack from the house. The police have no mental health powers in private premises. (The UK is almost the only country in the developed World not to extend police mental health powers to private premises.[15])

[15] Mental Health Cop: A Paramedic led incident. Inspector Mick Brown

12. Without disclosures and openness from the family and patient, neither the ambulance responder nor the police officers had the necessary understanding of mental health to recognise the more subtle signs of mental disorder. The ambulance responder wanted Jack to agree to a mental health assessment in hospital, based on what they had been led to believe was an old and relatively minor self-harming injury. At hospital, the Rapid Assessment Interface and Discharge Team [16](RAID) could have assessed Jack. The officers tried to persuade Jack, however he was adamant that he had to stay at home to support his father through chemotherapy the next day.
13. Faced with a refusal from Jack to be physically examined, the ambulance responder carried out visual checks for signs of injury and assessed the risk of self-harm/suicide using the SADPERSON (SADS).[17] The result of the assessment was that there was not a risk of suicide or self-harm as he scored 3, (low risk). The West Midlands Ambulance Service Independent Management Review indicated that the responder had made an error on the SADS and that it should have indicated a score of 4; medium risk. It appeared to the panel that this would probably not have altered the action taken as a result.
14. Recent National Institute for Health and Care Excellence (NICE) guidance on Self-Harm[18] has questioned the use of SADPERSON assessments; *'NICE CG 133_recommends that risk assessment tools and scales to predict future suicide or repetition of self-harm should not be used. Although methodologically limited, the evidence suggests that both the SAD PERSONS*

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[16] RAID is a specialist multidisciplinary mental health service, working within all acute hospitals in Birmingham, for people aged over 16.Providing;
one point of contact and access for the acute hospital, every referral in A&E to be seen within one hour and all other referrals seen within 24 hours, with appropriate and timely review, advice on alcohol problems, including detoxification and referral to our 'morning after clinic' or other community agencies, advice on substance misuse treatment, including methadone maintenance, assessment of care needs of older people with mental health problems,
early detection of mental health problems to enable rapid and appropriate intervention,

[17] SAD PERSONS is a 10-item scale (assessing: sex, age, depression, previous attempts, ethanol abuse, rational thinking loss, social support, organised plan, no spouse, and sickness) giving a score out of 10 which translates to a low, moderate, or high suicide risk.
[18] NICE CG 133 Self –harm: Longer term management (Evidence Update 39) April 2013

and modified SAD PERSONS scales have poor predictive ability for future suicide attempts.'

15. The behaviour of Jack was not such as to lead the professionals on scene to believe that a mental health crisis team needed to attend and commence the process which would allow the compulsory admission of Jack to hospital. Even had the risk of immediate self-harm / suicide been very evident, the only power to remove Jack to hospital available would be under the Mental Capacity Act[19] to prevent a '*serious deterioration in (Jack's condition).'*
16. West Midlands Police had access to a multi-disciplinary Street Triage team (police, paramedics, mental health nurse) who between the hours of 10:00am and 02:00 am can deploy to assist officers dealing with mentally vulnerable individuals particularly where police are considering using their powers under section 136 of the Mental Health Act to remove from a public place a mentally disordered person in immediate need of care or control to a place of safety. Had they been working their assistance could have been called upon which may have led to more informed questioning and awareness. West Midlands Police have informed the panel that the Street Triage team now cover 24 hours a day.

[19] Mental Capacity Act 2005 section 4 (a)(b)

4.5.1 What do we learn from the incident management during the acute mental health crisis of 7 July 2014
• Training for all emergency service responders (police and ambulance) should reinforce the need to seek to identify the caller and ensure they have all relevant information. • A reminder to current police and ambulance staff should be given based on the learning from this Domestic Homicide Review • West Midlands Ambulance Service should review the use of the SADPERSON assessment tool by responders in the light of current National Institute for Health and Care Excellence guidance. • Police powers in relation to mental health vulnerability in private are limited to arrest for criminal offences or breach of the peace making it particularly critical to identify possible arrest options during a mental health episode in the home.

5. Conclusions

1. This tragic case reached a crisis in the early hours of Monday 7 July 2014 during which Jack was in an acute phase of paranoid schizophrenia. Suffering from paranoid delusions and auditory hallucinations for some months, which had worsened in the preceding days, he feared he and his family would be victims of a gang who intended to torture and kill them all. Jack felt the need to keep his family close on the night in question and repeatedly armed himself with sharp instruments.
2. Immediately after the intervention of both ambulance and police services at the home address, his paranoia led him to conclude that he should kill his family to prevent them suffering worse at the hands of the ‘gang’. It is probably only the fact that she was upstairs and away from the immediate incident, which allowed Julie to flee to safety.
3. That Jack in the 36 hours before the homicides, had been subject to a mental health assessment in custody as a result of psychotic behaviour, had been to see a GP, and had police and ambulance present at his home after his sister alerted the emergency services that he was in crisis, makes the later homicides all the more terrible and hard to understand.

4. The practice of professionals assessing Jack appeared to be appropriate, and the panel concluded that based upon what they were being told by the patient and his family, they could not have anticipated the acute paranoid schizophrenic episode of Monday 7 July 2014. Only the Approved Mental Health Professional and the Section 12 mental health act doctors who saw Jack had the necessary experience of mental health to identify the subtle signs of an impending crisis. The conclusion they reached was a defensible one, made without awareness of all the relevant facts.
5. The General Practitioner in the Walk-In centre took advice from the on-call psychiatrist. Without open disclosure of all the symptoms and signs of deterioration, the General Practitioner did what was appropriate to assist Jack before he could visit his own General Practitioner on Monday.
6. The ambulance responder's training would provide a basic understanding of dealing with mental health patients, that of the frontline police officers considerably less. That they could not call on the mental health street triage car with their additional expertise was unfortunate since they may well have identified more concerns.
7. The panel felt that Jack's ability to engage with professionals in an appropriate way, even whilst in the midst of a schizophrenic crisis, might have contributed to the shared sense that he was not a significant risk to himself or others. With hindsight it is evident this was not the case. That someone in crisis can present in this way is something that needs to be highlighted in the mental health awareness training of all frontline professionals.
8. The family dynamic was highly significant in this case. Anna apparently had firm and entrenched views of mental health treatment that had led to problems and ultimately estrangement from David when he had experienced a psychotic episode. Her distrust of mainstream mental health treatment for David was a warning sign of how she would react to similar symptoms in her eldest son. This was not the supportive environment Jack would have required to be open and honest about his cannabis abuse and deteriorating mental health.

9. The review has shown that both Jack and Anna were very selective in what they disclosed to professionals. Jack had not acknowledged the full extent of his mental health problems, and Anna did not want to acknowledge them. Anna told Jack to 'act normally' in front of police and ambulance crew to prevent him being taken away. To a man suffering paranoid delusions that required him to stay with his family, these would have been influential words.
10. Julie probably alone understood the worsening mental health of her brother. She tried to persuade her mother to seek help for him but could not overcome her dominant personality and misinformed views. Her 999 call for help, in face of parental opposition, was in itself a considerable and courageous challenge to her mother.
11. That she could not bring herself to come downstairs to the emergency responders and contradict her brother and mother's accounts, is understandable but was with hindsight a pivotal moment. She was unambiguous and emphatic that had those responders sought her out, she would have told them that she feared her brother would kill them all.
12. Poor communication between the emergency control rooms of the police and ambulance services meant that their responders did not seek out the informant, Julie, either to ensure she was safe or to obtain her account. This was a very significant missed opportunity. The review has concluded that had she been spoken to the information she would have given would have compelled the police to take positive action to remove Jack preventing the tragedy that morning. Without that crucial information, the extent of Jack's crisis and the extreme risk to the family could not have been predicted.
13. If Jack had been arrested to prevent a breach of the peace, and had undergone a further mental health assessment in custody (where the incident on Saturday 5 July 2014 could have been taken into consideration) it is far from certain that the decision would have been to hospitalise him. It is possible that he would have been offered community mental health treatment. However had Julie expressed her concerns in the terms she used to the chair, it would have been a highly influential factor in any pre-release

assessment of the safety of Jack and his family. In any case, his removal would have prevented the tragic events that occurred in the family home.

6. Recommendations

6.1 Strategic recommendations of the Domestic Homicide Review Panel

Recommendation one

1a. That West Midlands Police and Hertfordshire Constabulary and commissioners of police custody health services relevant to these two Police areas should, in consultation with mental health services, consider the effectiveness of their mental health screening processes upon detention in light of the circumstances of this case. They should provide assurances back to the Safer Solihull Partnership of the robustness of the current systems to ensure that screening questions recognise and initiate appropriate response for vulnerable mentally disordered individuals held in detention.

It is suggested that a screening tool such as POLQUEST or equivalent tool should be adopted where present screening questions are less extensive than those in this model. Assurances should be given upon the date of completion of any changes.

1b. Assurances are sought that training of all detention staff is provided to include POLQUEST or equivalent tool that improves their awareness of mentally vulnerable individuals and offenders and enable early identification of concerns.

Recommendation two

That where a POLQUEST or equivalent screening tool has identified a mentally vulnerable offender/individual at immediate risk at the time of arrest/or whilst in custody, a post release referral to mental health services

should be made with the consent of the individual but subject to criteria established by Police forces without their consent if necessary and with regard to current guidance and legislation concerning disclosure or where other people are, or maybe, at risk including children.

Assurances are sought from West Midlands Police and Hertfordshire Constabulary that their current processes are compliant with this recommendation and if not what action will be taken in reply to achieve this as a minimum.

Recommendation three

That pre-release risk assessment should be completed for all vulnerable detainees released from police custody. Custody staff should in addition ensure appropriate referrals on release and obtain appropriate expert advice on the safety of others following the release of a detained person.

Assurances are sought from West Midlands Police and Hertfordshire Constabulary that their current processes are compliant with this.

Recommendation four

West Midlands Police and West Midlands Ambulance Service Domestic Homicide Review leads or relevant organisational leads should jointly consider the learning from this Domestic Homicide Review relating to call handling and review practice and procedures where incidents require both services.

- **This should include ensuring that call assessors from either service consistently identify risk within medical emergencies that may also be disorder or a risk of criminal injury to any person, or vice versa**
- **West Midlands Ambulance Service should ensure that their Computer Aided Dispatch system allows risk from criminal injury and disorder identified during a call about a medical emergency, to be 'flagged' to**

ensure that this information is always shared with West Midlands Police to allow officers to respond appropriately

- **Both services should review how incidents are supervised to ensure identified risk has been addressed before the Computer Aided Dispatch system is closed**
- **Both services to identify why current procedures can allow crucial information obtained by a call assessor not to be passed to a call handler and consequently not be shared with responders and effect necessary changes**
- **The Manual Dispatch Terminal used by the ambulance service should be reviewed to ensure that it is capable of providing a responder with both key medical but also critical safety information (West Midlands Ambulance Service)**
- **Training of call assessors should be reviewed to ensure it challenges assumptions arrived at from the tone and emotion of the caller**

Assurances are sought from West Midlands Police and West Midlands Ambulance Service of their organisational response to each of the points within this recommendation. The response should provide a statement back to Safer Solihull Partnership of any remedial action to be taken to meet these points as a minimum.

Recommendation five

That West Midlands Ambulance Service should review the SADPERSON risk assessment tool currently used by responders to predict future suicide or repetition of self-harm, in the light of current NICE guidance giving specific consideration to the fact that it should not be relied upon for this purpose. The service should give assurances back to Safer Solihull Partnership that it is compliant with nationally recognised best practice for assessing risk of self harm/suicide and change both their policy and practice accordingly.

Recommendation six

> **That West Midlands Police and Hertfordshire Constabulary in the light of section 9 of the Care Act 2014, consider and demonstrate that they understand local policies and procedures for Local Authority or Healthcare services; especially where it is believed a detainee has such care and support needs.**
> **That West Midlands Police and Hertfordshire Constabulary should identify with custody healthcare commissioners how, (with the consent of the detainee,) such referrals should be made and provide assurances back to the Safer Solihull Partnership of their considerations and findings.**

Recommendation seven

> **That the Safer Solihull Partnership require its five responsible authorities (Council, Police, Fire, Probation and Health) to include within its safeguarding training for front line practitioners the relationship between mental health and cannabis use. NHS England to be included.**

6.2 Appendices

6.2.1 The Terms of Reference

Terms of Reference for all agencies

1. To establish whether it was known, or could have been suspected that Jack posed a serious risk to Anna or John and whether any action could have been taken to prevent the homicide. To establish, therefore, whether the homicide was predictable or preventable.

2. To establish whether information was known or could have been established through disclosures by David or Julie that Jack posed a serious risk to Anna and John and whether any action could have been taken to prevent the homicide.

3. To identify how effective agencies were in identifying the risks that the alleged perpetrator, Jack, posed, and how effectively such risks were managed if identified.

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

Key lines of enquiry.

1: What knowledge did your agency have that indicated that Anna and\or John might be a victim and Jack a perpetrator of domestic abuse; and how did your agency respond to this information?
In considering your response, think about:

- Were practitioners aware of and sensitive to the needs of the victims in their work and knowledgeable both about potential indicators of abuse or neglect and about what to do if they had concerns about a victim's welfare?
- Did the organisation have in place policies and procedures for safeguarding and promoting the welfare of victims and acting on concerns about their welfare?
- What were the key relevant points/opportunities and decision making in this case in relation to the victims and family? Do assessments and decisions appear to have been reached in an informed and professional way?
- Did actions accord with assessments and decisions made? Were appropriate services offered/provided or relevant enquiries made, in the light of assessments?
- How, when and why did your agency share information with others and what was the impact?
- Was the supervision and management of the case in your agency effective and did it follow agency (and inter-agency) policies and procedures?
- To what degree did the victims' understanding of the risks impact on decision -making?
- Should the information known have led to a different response?

- Was anything known about the perpetrator? For example, were they being managed under Multi Agency Public Protection Arrangements (MAPPA)
- Was it reasonably possible, without the benefit of hindsight, to predict, and once predicted, work to prevent, the harm subsequently suffered?

What knowledge did your agency have that indicated that Anna and\or John might be a victim and Jack a perpetrator of domestic abuse; and how did your agency respond to this information

In considering your response, think about:

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

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

In considering your response, think about:

- Was there an adequate number of staff in post? Did any resourcing issues such as vacant posts or staff sick leave have an impact on the case?
- Was there sufficient management accountability for decision making?

- Were there any issues, in communication, information sharing or service delivery, between those with responsibilities for work during normal office hours and others providing out of office services?, particularly for Police, Health Services and the Ambulance service.

Enquiries specific to this review

a. **Young carers**
b. **Adult social services**
c. **Enquiries from relevant agencies in Hertfordshire Police and Mental Health Forensic Services**
d. **The impact of culture and language**
e. **Transfer from children's to adults services (esp. mental health)**
f. **Schools / Education services**
g. **University services**
h. **A response that relates to the specific vulnerabilities of each adult**.

Process

1. To identify key agencies and professionals involved with the deceased, the alleged perpetrator and other key family members and commission individual management reviews to be completed within one month of the date of request, detailing the nature and extent of their involvement. Agencies currently identified are:
   - West Midlands Police
   - NHS England (in respect of GP and walk in centre services)
   - Heart of England Foundation Trust
   - Birmingham & Solihull Mental Health Foundation Trust
   - West Midlands Ambulance Service
   - Hertfordshire Police and Mental Health Forensic Services

2. The Panel will receive the IMR reports from the above agencies and, based on the information provided, will consider the extent at which this review

may need to be extended to involve others. However, information reports to be requested from Manchester and Birmingham City Universities.

3. The review Panel will consider the completed Individual Management Reviews and information reports, seek additional information as required and, based on the information and analysis available will, together with the Review Chair, formulate any recommendations necessary to be presented to the Safer Solihull Partnership.
4. The Panel will undertake all the above actions and present findings to Safer Solihull Executive board.

Overview report

The Overview report will be published in full and should be produced in a manner that focuses on the professional involvement and inter-agency working with the family as opposed to the detailed history and experiences of the lives of the victim or others referred to. The report should identify the key inter-agency 'system' learning, good practice and specifically address:

(a) The effectiveness of multi-agency identification, analysis and management of risk and information sharing arrangements including any identified barriers to achieving effective management of risk.

(b) The quality of risk assessments and validity of any tools or processes used to identify protective factors as well as risk factors.

(c) The quality and impact of multi-agency planning and review processes used to promote improved outcomes.

(d) The impact and quality of professional supervision and its contribution to securing good quality practice including exploration of the 'rule of optimism' or any over-reliance on protective factors.

(e) The application of 'thresholds' and the degree of shared understanding and agreement across the partnership of those thresholds.

(f) Any ‘cultural practice norms’ that could impact on the professional network’s capacity to deliver high quality practice.

The findings from this Domestic Homicide Review should be considered alongside learning from Domestic Homicide Reviews conducted elsewhere, local audit findings, peer review feedback and findings from relevant research and take account of the socio-economic background of the family and their community.

To assess the quality of learning, identified by each agency submitting an Individual Management Review and the response to that learning.

To establish a multi-agency action plan as a consequence from any ‘system’ issues arising from the overview report.

Media Strategy

In accordance with Safer Solihull Communication Strategy, any media enquiries in respect of the Domestic Homicide Review will be managed by the Local Authority communications team, in conjunction with constituent partner agencies.