DOMESTIC HOMICIDE REVIEW

‘Jacob’

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1. INTRODUCTION

1.1 This report of a domestic homicide review examines how agencies responded to and supported Jacob, a resident of Manchester, prior to his death in early 2016. Jacob was killed by his son John on a Sunday while Joyce and her daughters were at church.

1.2 'In addition to agency involvement the review will also examine the past to identify any relevant background or trail of abuse before the homicide, whether support was accessed within the community and whether there were any barriers to accessing support. By taking a holistic approach, the review seeks to identify appropriate solutions to make the future safer'.[1]

1.3 'The key purpose for undertaking domestic homicide reviews is to enable lessons to be learned from homicides where a person is killed as a result of domestic violence and abuse. In order for these lessons to be learned as widely and thoroughly as possible, professionals need to be able to understand fully what happened in each homicide, and most importantly, what needs to change in order to reduce the risk of such tragedies happening in the future'.

[1] Home Office Guidance Domestic Homicide Reviews December 2016.

2. TIMESCALES

2.1 On 16 March 2016 Manchester Community Safety Partnership (MCSP) determined that the death of Jacob met the criteria for a domestic homicide review (DHR).

2.2 The first meeting of the review panel took place on 10 May 2016.

2.3 The DHR covers the period 1 May 2007 (the first date on which Greater Manchester Police (GMP) had a contact with Jacob in relation to domestic abuse) to the date of Jacob's death in early 2016.

2.4 The domestic homicide review was presented to Manchester Community Safety Partnership (MCSP) Board on 20 February 2018 and concluded on 18th April when it was sent to the Home Office.

3. CONFIDENTIALITY

3.1 Until the report is published it is marked: Official Sensitive Government Security Classifications April 2014.

3.2 The Chair of the review panel wrote to Joyce and her eldest daughter on several occasions inviting her to meet with him. The police Family Liaison Officer (FLO) interceded and spoke to Joyce about the value of taking part in the review. Joyce did make e-mail contact with the Chair and explained that the time was not right for her to meet the review team or contribute to the overview report. However, she selected the pseudonyms used within the report. She was also sent a copy of the report prior to it being sent to the Home Office. The names of any key professionals involved are disguised by use of an appropriate designation.

3.3 This table shows the age and ethnicity of the victim, Joyce and children.

Name	Relationship	Age	Ethnicity
Jacob	Victim	58	Black African
John	Son and perpetrator	21	Black African
Joyce	Wife of Victim	50	Black African
Jacob's eldest daughter	Jacob & Joyce's daughter & sister of John	22	Black African
Jacob's youngest daughter	Jacob & Joyce's daughter & sister of John	A Child	Black African

4. TERMS OF REFERENCE

4.1 The panel settled on the following terms of reference which the FLO gave Joyce when she delivered the letter notifying her of the review.

The purpose of a DHR is to:[2]

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

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

c) Apply these lessons to service responses including changes to inform national and local policies and procedures as appropriate;

d) Prevent domestic violence and homicide and improve service responses for all domestic violence and abuse victims and their children by developing a co-ordinated multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest opportunity;

e) Contribute to a better understanding of the nature of domestic violence and abuse; and

f) Highlight good practice.

Specific Terms

(1) What, if any, indicators of domestic abuse including:

a. Financial

b. Mental health

c. Safeguarding children and adults

[2] Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews [2016] Section 2 Paragraph 7

did your agency have in respect of the subjects and what was the response in terms of: risk assessment, risk management and services provided?

2. How did your agency ascertain the wishes and feelings of the adults and children in respect of domestic abuse and were their views taken into account when providing services or support?

3. Were there any barriers in your agency that might have stopped the victim from seeking help for the domestic abuse?

4. What knowledge did the family, friends and employers have of the adults' relationship, that could help the DHR Panel understand what was happening in their lives; and did family and friends know what to do with any such knowledge?

5. Were single and multi-agency policies and procedures followed; are the procedures embedded in practice and were any gaps identified?

6. How effective was inter-agency information sharing and cooperation in response to the subjects' needs and was information shared with those agencies who needed it?

7. How did your agency take account of any racial, cultural, linguistic, faith or other diversity issues, when completing assessments and providing services to the subjects?

8. How effective was your agency's supervision and management of practitioners involved with the response to needs of the victim and perpetrator and did managers have effective oversight and control of the case?

9. Were there any issues in relation to capacity or resources within your agency or the Partnership that affected your ability to provide services to the victim?

Other Matters

The role of the DHR Panel:

- To ensure the review is conducted according to best practice; with effective analysis and conclusions of the information related to the case

- The panel has the responsibility for quality assuring and challenging all the Individual Management Reviews [IMR's] submitted and the

overview report produced by the Independent Author for the DHR review conducted under the Home Office statutory guidance

- The panel will ensure that the final report recognises any experience of families, friends and colleagues and that this is approached in an open, true and honest manner

- The panel will identify any good practice, common themes and opportunities missed with a focus on lessons learned for agencies

- The panel is responsible for ensuring that the chair of Manchester Community Safety Partnership is briefed regularly on the progress of ongoing DHRs and any emerging recommendations

Agreement by Panel Members

- If a panel member is directly involved with this review, or there is any conflict of interest in a particular case, they should remove themselves from panel discussions

- Panel members have agreed to operate according to Manchester Community Safety Partnership DHR policy and sign confidentiality agreements

- Recognising that the review may identify significant learning for providers of services to the individuals involved in the case, panel members will be suitably positioned within their organisation to bring to the Panel their knowledge and expertise and ability to make decisions

- All panel members will contribute to the Panel process with information relevant to their organisation and specifically related to the individuals identified within the DHR

Membership commitment

- Panel members should ensure they prioritise the need to attend the meetings

- Where the panel member is unable to attend they should liaise with the chair of the panel to agree who will provide appropriate representation at the meeting

- Where possible a representative should be provided, this helps to ensure consistency in panel members

5. METHOD

5.1 Greater Manchester Police (GMP) notified MCSP of the homicide and that it potentially met the criteria for a domestic homicide review. The domestic homicide review panel called for reports from agencies on their contacts with Jacob and John. Using the agencies' information, the panel determined on 16 March 2016 that a domestic homicide review was required.

5.2 When the review panel met for the first time it determined which agencies were required to submit written information and in what format. Those agencies with substantial contact were asked to produce individual management reviews and the others, short reports. Some agencies interviewed staff involved in the case to gain a better understanding of how and why decisions were made.

5.3 The written material was distributed to panel members and used to inform their deliberations. During these deliberations additional queries were identified and auxiliary information sought.

5.4 Thereafter a draft overview report was produced which was discussed and refined at panel meetings before being agreed. Joyce was asked whether she wanted to see the report or be briefed on its findings before it was finalised. To date she has not responded which is consistent with her view that it was too early for her to be involved. Joyce will be re-contacted before the report is published and provided with another opportunity to see it. The report was presented to MCSP Board on 20 February 2018.

6. INVOLVEMENT OF FAMILY, FRIENDS, WORK COLLEAGUES NEIGHBOURS AND WIDER COMMUNITY

6.1 For the reasons set out in paragraph 3.2 the review panel have been unable to speak to Joyce or her children. The review panel recognise this represents a substantial gap in their knowledge of what was happening within Jacob's home and family. Family and friends often hold vital information that informs domestic homicide reviews. However, given the time that has now elapsed since Jacob's death and the completion of the criminal process, the review panel did not feel that it could delay the completion of its work any further.

6.2 The panel identified that Joyce and her family were members of a local church which they attended on the day John killed his father. The review panel chair wrote to the pastor there inviting him to contribute to the review: to date a response has not been received. Later the panel chair visited the church and while he was received with courtesy, he was unable to engage the pastor in obtaining background information. As Joyce does not feel able to engage with the DHR, out of respect, the panel decided it would not approach her place of work or make further approaches to the church without her consent. It was felt this would be intrusive.

6.3 In the absence of personal contact with Jacob's family the panel have relied instead on witness statements provided to GMP as part of the homicide investigation.

7. CONTRIBUTORS TO THE REVIEW.

7.1 This table show the agencies who provided information to the review.

Agency	IMR[3]	Chronology	Report
GMP	Yes	Yes	n/a
Manchester Youth Justice	Yes	Yes	n/a
Central Manchester Foundation Trust	Yes	Yes	n/a
North West Ambulance Service	Yes	Yes	n/a
Clinical Commissioning Group	Yes	Yes	n/a
John's last school	No	No	Yes
Revenue and Benefits Manchester City Council	No	No	Yes
Pennine Acute Trust	No	No	Yes
College Rochdale	No	Yes	Yes

7.2 The individual management reviews contained a declaration of independence by their authors and the style and content of the material indicated an open and self-analytical approach together with a willingness to learn. The authors explained they had no management of the case or direct managerial responsibility for the staff.

[3] Individual Management Review

8. THE REVIEW PANEL MEMBERS

8.1 This table shows the review panel members.

Name	Agency & Role
➢ Dr Erinma Bell MBE, DL	Independent Advisor Chrysalis Project
➢ Mark Brundrett	Youth Justice Service Manchester Manchester City Council
➢ Paul Cheeseman	Independent Author
➢ Leanne Conroy	Administrative Support-Crime & Disorder Manchester City Council
➢ Delia Edwards	Domestic Abuse Reduction Co-ordinator Manchester City Council
➢ Gail Heath	Independent Member- CEO The Pankhurst Trust (Incorporating Manchester Women's Aid) from 6 September 2016
➢ Michelle Hulme	Policy Specialist, Community Safety Team Manchester City Council
➢ David Hunter	Independent Chair
➢ Sarah Khalil	Designated Nurse Safeguarding, Manchester Clinical Commissioning Group
➢ Philippa Ladd	Independent Member-Strategic Manager, Manchester Women's Aid until 6 September 2016
➢ Nathan Percival	Detective Inspector GMP
➢ Christine Raiswell	Programme Lead, Public Health, Manchester City Council

8.2 The panel chair believed there was sufficient independence and expertise on the panel to safely and impartially examine the events and prepare an unbiased report.

8.3 The panel met six times and matters were freely and robustly considered. Outside of the meetings the chair's queries were answered promptly and in full.

9. CHAIR AND AUTHOR OF THE OVERVIEW REPORT

9.1 Sections 36 to 39 of the Home Office Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews December 2016 sets out the requirements for review chairs and authors. In this case the chair and author were separate persons.

9.2 The chair completed forty-one years in public service retiring, from full time work in 2007. The author completed thirty-five years in public service retiring from full time work in 2014. Between them they have undertaken the following types of reviews: child serious case reviews, safeguarding adult reviews, multi-agency public protection arrangements [MAPPA] serious case reviews and domestic homicide reviews.

9.3 The chair undertook domestic homicide reviews in Manchester in 2011 and 2013. The author worked with the chair on a review in Manchester in 2014 and wrote that report. Otherwise neither the chair nor author has ever worked in Manchester or for any agency providing information to the review.

10. PARALLEL REVIEWS

10.1 Her Majesty's Coroner for Manchester City opened a inquest into Jacob's death pending the outcome of the criminal trial.

10.2 GMP completed a criminal investigation and prepared a case for the Crown Prosecution Service and court.

10.3 The chair is not aware that any other agency has conducted a review or investigation into Jacob's death nor intends to do so.

11. EQUALITY AND DIVERSITY

11.1 Section 4 of the Equality Act 2010 defines protective characteristics as:

- age
- disability
- gender reassignment
- marriage and civil partnership
- pregnancy and maternity
- race
- religion or belief
- sex
- sexual orientation

11.1.2 Section 6 of the Act defines 'disability' as:

(1) A person (P) has a disability if—
(a) P has a physical or mental impairment, and
(b) The impairment has a substantial and long-term adverse effect on P's ability to carry out normal day-to-day activities[4]

11.1.3 There is evidence that John misused cannabis. Illegal drugs and alcohol are statutorily excluded from the definition of disability under the Act.

11.1.4 Jacob's Nigerian heritage did not preclude him from asking for or receiving services. His first language was English, and he never needed an interpreter.

11.1.5 No agency held information that indicated Jacob lacked capacity and there is no indication from the material seen by the review panel that a formal assessment of capacity was ever required for him.[5]

11.1.6 John had mental health needs. These appear to have been present for a period prior to the homicide of Jacob and are explored in more detail within section 15 of this report. Following his arrest John was compulsorily detained in a secure mental health hospital under the terms of the Mental Health Act 1983 as it was considered he was unfit to plead. He remained there until he was examined by a consultant psychiatrist in May 2017 when he was considered fit to plead.

[4] Addiction/Dependency to alcohol or illegal drugs are excluded from the definition of disability.
[5] Mental Capacity Act 2005

12. DISSEMINATION

12.1 The following organisations/people will receive or be offered a copy of the report after any amendment following the Home Office's quality assurance process.

- The victim's wife Joyce
- The perpetrator's Offender Manager from Her Majesty's Prison and Probation Service
- Manchester Community Safety Partnership
- Manchester City Council
- GMP
- Greater Manchester Mental Health NHS Foundation Trust.
- North West Ambulance Service
- Manchester Clinical Commissioning Group
- Pennine Acute NHS Foundation Trust
- College attended by John
- HM Coroner for Manchester
- Manchester Safeguarding Children Board
- Manchester Safeguarding Adults Board

13. BACKGROUND INFORMATION [THE FACTS][6]

13.1 Jacob was born and raised in Nigeria. Joyce was born in the UK. They met in Nigeria when he was 34 years of age and she was 26 years of age. They married in 1993. At that time Jacob worked in a launderette. John and his older sister were born in Nigeria.

13.2 Jacob wanted to move to the UK for a better life and Joyce returned there in 1997 with the two children. Jacob joined them in 2000. Joyce worked as a healthcare professional in the Manchester area. Jacob held several jobs as well as periods without employment. Their youngest daughter was born in the UK and, shortly after, the couple bought their own house in Manchester as Jacob wanted financial security.

13.3 Joyce said Jacob suffered from high blood pressure and, about 3-4 years before his death, had a fall downstairs which affected one of his legs. Joyce felt this incident affected Jacob's health. For example, she says that after the fall he became argumentative when alcohol was involved. Accident and emergency records confirm Jacob attended there after falling downstairs. The record shows he did not suffer any serious injury.

13.4 John lived with his parents and sisters in the family home in Manchester. He was educated in local schools and attended college. Neither his primary school nor secondary school had any safeguarding concerns in relation to John. Records provided for the academic year 2011/12 indicate that John received mainly excellent or outstanding achievement reports. Conversely, the records for behaviour during that period identify several occasions when he was reported to be defiant, disruptive or threatening. That behaviour correlates with a period during which he came to the attention of GMP and was convicted for several offences which attracted a custodial sentence. Upon release he attended several sessions with a specialist provider to address his use of cannabis.

13.5 In September 2012 John attended College to study for an information technology qualification. His attendance and punctuality were poor, and he received repeated warnings. Around September 2014 friends and tutors became concerned about his mental health. He was encouraged by a tutor to access a mental health service and was persuaded to contact the African and Caribbean Mental Health Team. An appointment was arranged but he did not attend. In 2015 John left college and enrolled for a three-year

[6] The information contained within this section was obtained from witness statements provided to GMP as part of the homicide investigation.

computer course at a local University. His record of attendance there was also poor, and a year's interruption of study was made with effect from 3 March 2016. John was subsequently withdrawn for failure to re-register back at the University.

13.6 Joyce says she noticed a change in John's behaviour two to three weeks before he killed his father. Other witnesses have similar recollections although they place the changes earlier. However, they are consistent in the sort of behaviour they describe.

13.7 The change in John's behaviour was said to have started when he became disrespectful to his mother. John also argued with his elder sister after she told him he needed to speak to their mother in a more respectful manner. This argument ended when John struck his elder sister. Joyce made an appointment for John to see the GP. However, he never attended as the date of the appointment fell after the homicide of Jacob.

13.8 Joyce also noticed that John was spending his student loan very quickly. She offered to support him financially. However, John then accused Joyce of not repaying money he had lent her which was untrue. Jacob bought John a car for which he paid £400. On this occasion John, falsely, said he had lent Jacob the money to buy the car which caused Jacob to become annoyed.

13.9 Evidence from witness statements provide other examples of John's unusual and often threatening behaviour. Joyce described an incident that took place on 1 February 2016 when John took a knife and wounded his elder sister. Paramedics and police officers attended. However, for reasons set out later in this report (see paragraph 15.3.16), neither the paramedics nor police officers were aware a weapon had been used nor the full extent of the incident.

13.10 On 15 February 2016 Joyce told John to leave the house after he had been disrespectful to her. He returned later and kicked at the door of the house and Joyce rang the police who removed him and took him to the bus station (see paragraph 15.3.37). The following night Jacob and Joyce were in bed when John again returned home and started kicking at the door. Jacob went to the door and Joyce recalled hearing him shout that John had hit him. On this occasion the police were not called, and the family went to stay with relatives.

13.11 Later that week Jacob told Joyce that he had tried to talk to John in a calm manner. John said he did not want to talk to him. Joyce suggested to Jacob

that John needed help and that Jacob should leave John until this was available. This annoyed Jacob. Joyce felt Jacob did not understand that John's behaviour was not normal. She felt John needed psychiatric help.

13.12 Joyce suspected John was using cannabis: something Joyce says he had done before in 2014. During this period of unsettled behaviour John had told his elder sister he believed Jacob and Joyce were not his parents. His mother says he was sleeping with the light on and appeared scared of something. The night before he killed Jacob, Joyce says John was pacing up and down stairs until midnight. That was the last occasion on which she spoke to her son.

13.13 On the day of the homicide, Joyce and her daughters attended church leaving Jacob and John in the family home. There were no independent witnesses to the events that followed. At 13.18hrs that day North West Ambulance Service (NWAS) received a telephone call from John requesting an ambulance attend the family home.

13.14 Paramedics found Jacob lying on the floor with a neighbour holding his head. The paramedic ascertained that Jacob was dead. Police officers attended, and John was arrested on suspicion of murdering his father. A pathologist concluded that Jacob died from multiple stab wounds.

13.15 When interviewed John said he argued with Jacob and punched him in the mouth. He claimed Jacob retaliated by swinging a punch which missed. John then picked up a kitchen knife and stabbed Jacob. John was charged with Jacob's murder and remanded in custody. However, John was assessed as suffering from mental illness and detained in a secure hospital as he was unfit to plead.

13.16 While in hospital he was seen by several clinicians instructed by both the Crown and the defence. An initial diagnosis indicated he was suffering from paranoid psychosis most likely triggered off by using marihuana. John gave clinicians accounts of the confrontation with his father claiming that Jacob had been violent towards him and had been aggressive when he answered the door to John. He also claimed he was working 'undercover' and that Jacob was not his father. The review panel have found no evidence to substantiate these claims, both of which are refuted by Joyce.

13.17 John was detained in hospital where he remained until he recovered and was assessed as fit to plead. He appeared before the Crown Court and pleaded guilty to the manslaughter of Jacob on the grounds of diminished

responsibility. These pleas were accepted and, following a diagnosis of paranoid schizophrenia, John was sentenced to a section 37 hospital order[7] with a section 41 restriction[8].

13.18 Joyce has memories of family time spent with Jacob and the children. She says Jacob was generous and friendly and cared about the safety of his family. The couple had plans and had started to raise money to build a house in Nigeria. Joyce says that she will miss Jacob and his company.

[7] S37 Mental Health Act 1983. This is a court order imposed instead of a prison sentence, if the offender is sufficiently mentally unwell at the time of sentencing to require hospitalisation
[8] S41 Mental Health Act 1983. This order is imposed to protect the public from serious harm. It places restrictions on leave of absence, transfer between hospitals, and discharge. These require the Ministry of Justice to grant permission.

14. CHRONOLOGY

14.1 The following table contains events which help with the context of the domestic homicide review.

Event Table	
Date	**Event**
8.05.07	Domestic abuse call to GMP concerning a verbal argument between Jacob and Joyce.
28.10.07	Jacob was arrested for abusive behaviour at work while intoxicated and given a fixed penalty notice.
6.12.10	Joyce reported domestic abuse by Jacob. He was arrested for assault. Joyce chose not to take any action.
16.11.11	John was made the subject of a referral order under the supervision of Manchester Youth Justice.
10.01.12 To 20.10.12	John committed offences of robbery (x5) and attempt robbery.
23.01.12	John was made subject of an intensive supervision and surveillance bail programme.
23.04.12	John was sentenced to 8 months custody in a young offender's institute.
22.08.12	John was released on licence.
30.08.12	John was referred to Eclypse (drug and alcohol service) to help him deal with his use of cannabis. He attended several sessions with a practitioner from Eclypse.
5.12.12	John complied with the treatment plan and was discharged at which time he was reported as being an occasional user of cannabis.
09.12	John enrolled at College for an information technology course.
30.01.14	John was taken to see a GP by his mother in relation to his misuse of cannabis.
21.03.14	GMP officers searched John and found him in possession of cannabis. He was given a warning.
15.04.14	GMP officer searched John and found him in possession of cannabis. He was given a fixed penalty notice.
2.10.14	Concerns raised by students and tutors at College about John's mental health. He denied misusing drugs. The college contacted Joyce and she agreed she had seen a change in his behaviour and supported him attending to see a GP.
6.10.14	John attended his GP for a memory test following concerns raised by the college.

24.04.15	John met with a tutor from college in relation to his current mental health. It was suggested he should receive support from the African Mental Health team. A referral was made, and John did not attend.
30.4.15	John was described by a tutor as 'vacant' and was advised to seek support.
1.02.16	GMP received a call about a disturbance at the family home. Ambulance were also called. John had injured his elder sister with a knife. She refused treatment and their mother told the police this was an argument between her and her eldest daughter.
2.02.16	GMP visited Joyce and her eldest daughter and they repeated the explanation that the event yesterday was an argument between them.
15.02.16	GMP are called to the family home and are asked to remove John who was at the front door causing a disturbance.
16.02.16	John returned home and gained entry to the house and assaulted Jacob by punching him.
16.02.16	John was arrested and then released from custody on suspicion of attempted theft of a car.
February 16	John stabbed Jacob at the family home.

15. OVERVIEW

15.1 Introduction

15.1.1 This section of the report summarises what information was known to the agencies and professionals involved with the victim and perpetrators. The analysis of the contacts appears at section 17. The information in this section is drawn from agencies who submitted IMRs, chronologies and reports together with information provided to the homicide enquiry. The main analysis of events appears in Section 16.

15.2 Events within the review timescale

8th May 2007-Domestic Abuse Call

15.2.1 A female (believed to be Joyce) made a 999 call to the police which was abandoned part way through. The caller was distressed and wanted to report 'domestic violence'. Officers from GMP attended. They spoke to Jacob and Joyce. They had argued over money after Jacob returned from a twelve-hour shift as a security guard. No allegations were made by either of them and there was no evidence either were injured.

15.2.2 The incident was recorded on GMP FWIN[9] system. A risk assessment was completed in accordance with contemporary GMP policy. The incident was assessed as a 'standard risk'[10]. Children were recorded as being present and unaffected by the incident. Neither drugs nor alcohol had been contributory factors.

15.2.3 Specialist staff in the police Public Protection Investigation Unit (PPIU) reviewed the risk assessment and referral letters were sent to the local health visitor and Children's Social Care (CSC) to inform them about the incident. Joyce was sent a letter offering her additional support. She did not have any further contact with GMP regarding this matter.

28th October 2007-Abusive Behaviour by Jacob

15.2.4 On this date officers from GMP were called to Jacob's place of work. Jacob had presented at work intoxicated and was then abusive towards a supervisor. Police officers arrested Jacob for abusive behaviour and took him into custody. He was then released and issued with a fixed penalty notice.

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[9] See Appendix A for a description of FWIN and other systems in use within GMP.
[10] See Appendix A for a description of the risk assessment processes used by GMP.

6th December 2010-Domestic Abuse Call

15.2.5 Joyce made a telephone call to GMP and said she had been assaulted by her husband. The FWIN relating to her call states she had been 'beaten up' by Jacob and that this had occurred before.

15.2.6 A police officer from GMP attended. Jacob had punched Joyce several times to the head. This followed an argument between the couple who were struggling financially because he was now unemployed. Joyce had bruising to her face and a nosebleed. The officer arrested Jacob. Joyce did[11] not want to make a statement supporting a prosecution and Jacob was released from custody without charge.

15.2.7 The police officer attending completed a risk assessment in accordance with contemporary policy[12]. This identified the couple had three children, none of whom were present at the time of the assault. The assessment also indicated that neither alcohol nor drugs were considered contributory factors. The risk to Joyce from her husband was assessed as 'standard'.

15.2.8 The Public Protection Investigation Unit reviewed the risk assessment and the previous incident in 2007. A letter was sent from the Public Protection Unit offering Joyce support. The incident was also referred to the victim support service and children's social care. There is no record of any subsequent contact by Joyce to the Public Protection PPIU staff or vice versa.

October 2011-January 2012-Offences Committed by John

15.2.9 John was arrested for an offence of assault and made the subject of a nine-month Referral Order on the 16 November 2011. He was then under the supervision of Manchester Youth Justice[13]. While under supervision, between 10 January 2012 and 20 January 2012, John committed five offences of Robbery and one offence of Attempt Robbery. These were committed whilst he was a member of a group of youths who offended together on the Manchester Metrolink system.

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[11] The DHR review panel recognise there are many reasons why victims do not pursue reports of domestic abuse. Reasons victims gave were identified in a survey as: fear of retaliation (45 percent); embarrassment or shame (40 percent); lack of trust or confidence in the police (30 percent); and the effect on children (30 percent). Source: Everyone's business: Improving the police response to domestic abuse; HMIC March 2014

[12] At that GMP used a 13-point risk assessment. They did not move to the DASH risk assessment process until 2011/12.

[13] Manchester Youth Justice is a multi-agency service that aims to prevent offending and re-offending by children and young people. The core work of the YJ involves the supervision of Court Orders.

15.2.10 John was made the subject of an Intensive Supervision and Surveillance Bail Programme at Bury Court on the 23 January 2012. He was sentenced to an eight-month Detention and Training Order on the 23 April 2012 and served four months in custody in a Young Offenders Institute. He was released on 22 August 2012 and was subject to a four-month licence. He successfully completed his licence conditions and his final contact with the Youth Justice Service was on 19 December 2012.

August 2012-John's treatment for drugs misuse

15.2.11 On release from his custodial sentence John was referred to Eclypse[14]. John reportedly wanted to deal with his misuse of drugs by not smoking cannabis daily. He attended several sessions with a specialist worker. He met all his targets and, while not ceasing to misuse cannabis completely, he reported that he had periods of abstinence and was not smoking cannabis each day.

15.2.12 During one of the sessions John said he had some difficulties in dealing with the cultural differences because of his African inheritance and living in the UK. John believed that, because of his parent's culture, they had high expectations in respect of his academic achievements.

15.2.13 In December 2012 John was discharged from treatment having completed the agreed plan. At this point he was recorded as an occasional user of cannabis. When discharged John said he was doing very well at college. He felt that by reducing his cannabis use and achieving success at college he was more integrated and accepted by his family.

30 January 2014-John visits a GP in relation to misuse of drugs

15.2.14 Joyce made an appointment for John to see a GP because she was worried he may be misusing drugs. She had tested John using a kit she had purchased on-line and this had returned a positive result. The GP saw John alone and then with his mother. John told the GP he used about one bag of cannabis a week. He said he did not use any other drugs. John told the GP that he sometimes argued with his parents because of their attitudes to his lifestyle. The GP found no evidence that John was mentally unwell.

15.2.15 The GP advised and reassured Joyce and told her that if she was worried about her safety she should involve the police. The GP then made a referral to the Alcohol and Drugs Service. Unfortunately, no record can be found that this referral was received or, if it was, whether John attended.

[14] Eclypse is a free and confidential drug and alcohol service for young people under 19 and families in Manchester. The treatment team works with young people under 19 years who are using or at risk of using drugs and alcohol.

15.2.16 In her witness statement Joyce refers to this GP visit. She makes no reference to John being offered or attending a visit to the Alcohol and Drugs Service. However, Joyce does say that she booked a private counselling session for John in the Prestwich area. Joyce says John only attended once and he told his mother the counsellor "just asked him questions".

21st March 2014 and 15th April 2014-John found in possession of cannabis

15.2.17 On both occasions John was searched by officers from GMP and found to be in possession of cannabis. He received a formal warning on the first occasion and a fixed penalty notice on the second. This is the only information known to the police, prior to the homicide of Jacob that links John to cannabis use.

October 2014-April 2015-Concerns raised by College regarding John's mental health

15.2.18 John had enrolled with College in September 2012 for a course in information technology. Records provided by the college show that his attendance and punctuality were very poor. There are numerous entries from staff members referring to John either not attending a class or attending late. Often, he would come without a pen or paper and on other occasions claimed he was unable to log onto the college's computer system. Despite his poor attitude to learning the college repeatedly encouraged him to change, offering support and a range of different strategies to help him improve.

15.2.19 Mental health issues were first recorded on 23 September 2014 when students told a tutor at the college that John had been talking to himself. On 26 September John was seen by a member of staff who tried to persuade him to engage with a counsellor from the college and to see a doctor.

15.2.20 On 2 October 2014 John was seen by a student support tutor. They told him they were concerned about him and he agreed to go to the doctors and attend a counselling session to assess his mental health. John told the tutor he was not misusing drugs although he had smoked 'weed' in the past. He gave the tutor permission to ring his mother. She spoke with the tutor and agreed that she had noticed a change in John's behaviour and she would support him going to see the doctor. The tutor asked for permission to see the letter from the doctors regarding the assessment. The letter was never provided.

15.2.21 On 6 October 2014 John attended the GP surgery with his mother in response to the concerns raised by the college. He was said to be suffering from short term memory issues; often repeating things that were said to him as if his mind was not processing them. The GP carried out a Mini Mental State assessment and identified that the only issue seemed to be that John did not know todays date. John told the GP he would get a letter from the College articulating their specific concerns. There is no indication John ever asked the college to provide this. The GP recorded that John would be reviewed at his next appointment. This was the last contact John had with his GP.

15.2.22 On 4 February 2015 John was again seen by a member of staff and agreed to see a counsellor at the college. A referral was made for John to attend a drop-in session at the college. Over the next week several calls were made to Joyce and a message left in relation to his mental state at college and to obtain the details of his doctor to arrange an appointment. Joyce did not respond to these calls.

15.2.23 On 24 April 2015 a student support tutor met with John in respect of his mental health state. They discussed making an appointment with a counsellor to discuss problems he had been experiencing at home and in college about his wellbeing. The tutor also suggested John get support from the African/Caribbean Mental Health team. The tutor said he would make a referral to the service and would contact Joyce.

15.2.24 On 30 April 2015 John met with the same tutor again. This related to an accusation that he had assaulted another student. The tutor described John as being "vacant minded…(he) seemed to stare into space sporadically during conversations". When asked why he had attacked the other student John said, "he shouldn't look at me I don't like people looking at me". While he reluctantly apologised to the victim the tutor felt John did not seem to grasp that his actions were uncalled for. The tutor again discussed with John taking up the earlier offer of support from the African/Caribbean Mental Health team. John was given a leaflet that explained what the service offered.

15.2.25 While there is no evidence John attended the counselling sessions or the African/Caribbean Mental Health team, his academic work did seem to improve in his last few weeks at college. On 9 June 2015 the college recorded that John sat his GCSE English exam, seemed to have "turned things round for the better" and had been offered a place at University.

Enrolment at the University

15.2.26 John applied through the UCAS system for a place on a Bachelor of Science programme in Computer Networks in the School of Computing, Science and Engineering at University. A conditional offer was made on 7 February 2015. John registered with the University on 23 September 2015.

15.2.27 His attendance was poor and emailed communications were made from the school's student progression assistant in November 2015 and February 2016 respectively. In view of John's poor attendance and lack of engagement, a year's interruption of study was made with effect from 3 March 2016. John was subsequently withdrawn for failure to re-register back at the University after the interruption of study period.

15.2.28 The University's Head of Student Support confirms that John did not present himself to student welfare and student support regarding mental health, safeguarding, substance abuse, domestic abuse or violence, or any other matters relating to student welfare and support. No safeguarding concerns were identified in relation to John.

Monday 1st February 2016-Domestic Abuse Incident Address One

15.2.29 At 08.49 GMP were informed of an abandoned 999 call. This call had been made from a mobile telephone. The female caller was distressed, and a disturbance could be heard in the background. The caller (later identified as Jacob's eldest daughter) only said three words to the emergency services (999) operator, these were;

"Hi there…, sorry."

15.2.30 When the call was passed to GMP a FWIN was created and the incident was allocated an opening code of "D05". This code identified the incident as a potential domestic abuse incident. It was allocated a priority grading of "2" in line with Greater Manchester's graded response policy[15].

15.2.31 The GMP author states the information recorded on the log was potentially misleading. This is because the words "no disturbance" was recorded on the FWIN. The IMR author has listened to the recording and there is audible evidence of shouting. This discrepancy is considered in more detail at section 16 of this report.

15.2.32 At 08.57 the call taker from GMP telephoned the mobile number provided by the 999 operator. The mobile telephone belonged to Jacob's eldest

[15] A grade 2 response means that the incident should be attended within one hour. The grade for this incident was in line with the very limited information known to the call taker

daughter and was answered by Joyce. She sounded upset and said she had argued with her eldest daughter over a personal issue. The GMP call taker then spoke with the eldest daughter. Neither she nor her mother chose to provide any further information. Joyce said the 999 call had been a 'mistake'.

15.2.33 The call taker recorded that no injuries or weapons were involved; no children were present; nobody was in immediate danger; alcohol was not a factor; and there had been no similar incidents previously. This record was based upon information provided over the telephone by Joyce and/or her eldest daughter[16]. From the information provided it appeared there was no immediate risk to life or personal safety.

15.2.34 There were no police resources immediately available to attend and therefore the response could be delayed for 20 minutes. By 09.55 there were still no patrols available to attend. As the call had now fallen outside the policy, as no patrol had attended, the on-duty Sergeant and Inspector were informed.

15.2.35 At 10.02 the same day North West Ambulance Service (hereinafter referred to as the ambulance service) contacted GMP. They said an unidentified male telephoned and asked for an ambulance to attend Jacob's address. The male said this was; "because a female had been cut on the shoulder"'. The telephone number the male used was recorded although his identity was not. The ambulance service asked the police to attend the address to support the paramedics. The police call taker quickly made the connection: that the earlier call to the police and this call to the ambulance service all related to Jacob's family.

15.2.36 The police call taker told the ambulance service about the earlier call and said there were no police patrols available to attend immediately. The ambulance crew arrived at the family home at 10:03. There was no response from knocking on the front door. The crew persisted and eventually a woman opened an upstairs window, lent out and spoke to the crew. She said she did not require an ambulance and was about to go into the shower. The crew asked the lady to come downstairs and speak to them. They say the front door did eventually open, although only by a couple of inches. The description of the female matches Jacob's eldest daughter. She refused treatment and the crew returned to the ambulance.

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[16] It later emerged during the homicide enquiry that some of the information provided was not accurate

They were not comfortable with the incident and asked their control room to re-contact the Police for a welfare visit.

15.2.37 At 11.23 a police call taker made a telephone call to Joyce. She said she had not contacted the ambulance service and there was no male at the address. She said her child youngest daughter had gone to school and her eldest daughter had gone out to work. Joyce said she was not able to wait for the police to visit her and she would not be available for the next four hours.

15.2.38 Attempts were made by the police to arrange a time to see Joyce and her eldest daughter. This did not happen because no police patrols were available. Joyce was finally seen in person at 17.17hrs the following day Tuesday 2 February 2016. The officers that attended knew very little about the original 999 call and relied upon what they were told by Joyce and eldest daughter who they saw separately.

15.2.39 The following is an extract from the FWIN log;

"I have spoken to both Jacob's eldest daughter and Joyce separately and both have stated that they had an argument over a personal matter, both would not say what this matter was about other than it was personal, and everything is ok now. Jacob's eldest daughter stated that she contacted the police out of frustration and anger. Both stated no violence was used, there is no toxic trio[17]".

15.2.40 The log was endorsed as a "Verbal only domestic, no children, no alcohol" Jacob's eldest daughter was recorded as the victim and Joyce as the perpetrator. A DASH risk assessment was completed and the answer to every question was recorded as 'No'. The risk was recorded as 'Standard'. The officers that attended recalled a young male was present in the house. It is highly likely (although not confirmed) this was John.

15.2.41 It appears the police officers that attended and completed the risk assessment believed the dispute was between Jacob's eldest daughter and Joyce. It was only when Jacob's eldest daughter was seen as part of the homicide investigation that the police discovered what had really occurred. In her witness statement Jacob's eldest daughter says John pushed the door open and came into the family home. He had a knife in his hand which he was waving about. Jacob's eldest daughter grabbed a mop to defend herself and John was shouting for his mother to come downstairs.

[17] Drugs, alcohol and mental health

15.2.42 John cut his eldest sister on the chest with the knife. Joyce used a mirror to push John out of the house. After John left the house Jacob's eldest daughter telephoned the police. However, when she was put through to an operator, she put the telephone down because she says she was in shock and was not able to speak. Jacob's eldest daughter says the police telephoned back and she then told them that everything was fine.

15.2.43 Jacob's eldest daughter says that while Joyce was cleaning her up an ambulance arrived at the home. She was surprised, as neither she nor her mother had telephoned for an ambulance. Jacob's eldest daughter says the paramedics told her that a male had contacted the ambulance service. The eldest daughter says she told the paramedics she did not need an ambulance and they left.

15th February 2016-Report of Attempted Break In-Address One

15.2.44 At 20.35hrs police officers attended a report of an attempted break in at the home of Jacob and his family. Police officers attended and found John outside. He wanted to collect some items from his room and Joyce had refused to let him in. She had a conversation with the police officer through an upstairs bedroom window. She kept telling the officer to "take him (John) away." To prevent the risk of disturbance the police officers took John to a bus station in Manchester at his own request.

16th February 2016-Arrest of John on suspicion of attempted theft of a vehicle

15.2.45 Police officers attended a garage in Manchester after staff reported a male, found to be John, was behaving 'unusually'. He was sitting in cars on the garage forecourt, going through the contents of the vehicle and was said to seem confused although apparently not under the influence of drink or drugs. John was arrested on suspicion of attempting to steal a car. The police officers that attended say that, while John's behaviour was unusual, and he was argumentative, there was no reason to believe he was suffering from any mental health issues.

15.2.46 John was taken to a GMP custody suite. The arresting officers told the custody officer about John's unusual behaviour. The custody officer conducted a risk assessment concerning John's fitness to be detained. The result of this assessment was recorded on the custody log and no mental health concerns were identified. John requested that an uncle be informed of his arrest and asked for the duty solicitor.

15.2.47 While in custody John asked to see a doctor as he complained of a sore stomach. He was seen by a MEDACS health professional[18]. The record from MEDACS includes the following commentary;

'Diagnosis - Mood stable, no mental health issues voiced or self-harming. Asked for paracetamol for stomach ache, same given. DP denies any use of illicit drugs, but he seemed to draw a blank face at times when spoken to.'

Fit to be detained – Yes; Fit to be interviewed – Yes; Appropriate adult required – No; Fit to be processed – Yes; Fit to be transferred – Yes; Fit to be released – Yes; Suicide risk – Standard; Safety in detention – Level 1, hourly checks; Medical review required – No.

15.2.48 John voluntary took a test for class A drugs while he was in detention. This indicated there was no heroin or cocaine present in his system. John's continued detention was reviewed by an Inspector and this did not indicate any issues of concern relating to him remaining in custody.

15.2.49 By midnight, enquires to identify the owner of the vehicle that John was found in had not been completed. The custody officer therefore released John on bail with a duty to return on 28 February 2017 when the enquiries into ownership of the car would have been completed. The custody officer completed a risk assessment that showed John was physically and mentally competent to be released from custody.

15.2.50 At 13.30pm on 17th February 2016 GMP received a further report stating John had returned to the garage. He claimed a car belonging to him was being repaired there. It was not. The police IMR author has listened to the recording of the telephone call made from the garage. It appears the caller had concerns about John's mental health. John left the garage prior to police attendance and was not seen nor spoken to by any police officers on this occasion.

15.2.51 The suspected, attempted theft of the vehicle was still being investigated at the time of John's arrest for the murder of Jacob. Since then the police have completed their enquiries into the matter of the car and found there was insufficient evidence to proceed with the matter.

[18] MEDACS is a private company contracted to provide professional medical assessment and minor treatment to detainees in custody throughout Greater Manchester.

16. ANALYSIS AGAINST THE TERMS OF REFERENCE

Each term appears in ***bold italics*** and is examined separately. Commentary is made using the material in the IMRs and the DHR Panel's debates. Some material would fit into more than one term and where that happens a best fit approach has been taken.

16.1 *What, if any, indicators of domestic abuse including:*

a. Financial

b. Mental health

c. Safeguarding children and adults

did your agency have in respect of the subjects and what was the response in terms of: risk assessment, risk management and services provided?

16.1.1 In considering this case the DHR review panel took cognisance of information[19] issued by the Home Office in relation to Adolescent to Parent Violence and Abuse (APVA). The cross-Government definition of 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 psychological, physical, sexual, financial and emotional abuse'.

While this definition applies to those aged 16 or above, APVA can equally involve children under 16.

16.1.2 The information guide highlights that there is no legal definition of APVA. However, it is increasingly recognised as a form of domestic violence and abuse and, depending on the age of the child, it may fall under the government's official definition of domestic violence and abuse. In Manchester children under 16 years old who are violent towards their parents or family members are dealt with via child safeguarding procedures.

[19] Information guide: adolescent to parent violence and abuse (APVA) Home Office

16.1.3 In considering the scope of APVA the information guide states that is likely to involve a pattern of behaviour. This behaviour can take many forms including violence towards a parent, damage to property, emotional abuse, and economic/financial abuse and patterns of coercive and controlling behaviour.

16.1.4 The information guide says that in relation to APVA, it is important to gain an understanding of the pattern of behaviour behind an incident; the history of the relationship between the young person and the parent and the pattern of behaviour in the family unit. APVA is not specifically recorded by police forces and therefore it is difficult to establish how prevalent it is. The information guide states that incidents of APVA that are reported to the police are likely to represent only a small percentage of actual incidents and actual levels are likely to be much higher.

16.1.5 There are many reasons why APVA may be under reported. Some of these reasons concern the beliefs and attitudes of parents. They may feel isolated, guilty, shameful. They may fear their parenting skills will be questioned, they will be blamed or disbelieved, they fear they will not be taken seriously and they will be held to accounts or their children taken away from them.

16.1.6 APVA is a complex topic. The DHR panel have not been able to talk to Joyce and her family to establish the full extent of their experiences. That means they have not been able to gain a full understanding of the history of John's relationship with his parents and family. However, from the limited information they do have the DHR panel believe that John's behaviour towards them was an example of APVA and mirrors many of the examples of the behaviour set out in the Home Office information guide.

16.1.7 GMP attended two incidents of domestic abuse that occurred over three and a half years apart on 8th May 2007 and 6th December 2010 (see paragraphs 15.2.1 and 15.2.5 respectively). Both involved Jacob and Joyce only. On the first occasion GMP recorded that the children were present, and referrals were made to health visitors and children's social care. On the second occasion the records indicate the children were not present. The review panel felt it was important to recognise that the referral made by GMP in relation to domestic abuse was picked up and identified as a factor when John committed criminal offences and was placed under the supervision of Manchester Youth Justice.

16.1.8 The DHR review panel felt it was important to recognise the information contained within the Home Office information guide about explanations for APVA;

'there is no single explanation for APVA and the pathways appear to be complex. Some families experiencing APVA have a history of domestic violence and abuse. In other cases, the violence is contextualised with other behavioural problems, substance abuse, mental health problems, learning difficulties, or self-harm. In some cases, there are no apparent explanations for the violence and some parents find it difficult to understand why one child is aggressive towards them when their other children do not display such behaviour'.

16.1.9 The panel discussed the reported incidents of domestic abuse within the household. The panel acknowledge there is often significant under reporting of domestic abuse. For example, research[20] found that only a minority of incidents of domestic violence are reported to the police, varying between 23% and 35%. As set out earlier (footnote 11) the panel also recognised there are many reasons why victims choose not to report their experiences to the police. Taking these factors into account the panel recognised that the two reported incidents of domestic abuse may not have represented the real extent of domestic abuse within the family. However, in the absence of a conversation with Joyce the panel is not able to reach a view as to the extent of her or her children's experiences of domestic abuse.

16.1.10 While recognising that Jacob is the victim of homicide at the hands of John, the panel felt it was important to consider the extent to which exposure to domestic abuse can impact upon the lives of children. The panel took cognisance of important findings within a report published by CAADA[21]: In Plain sight: Effective support for children exposed to domestic abuse (2014). The report states an estimated 130,000 children in the UK live in households with high-risk domestic abuse and 6% of all children are estimated to be exposed to domestic abuse between adults in their homes at some point in childhood.

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[20] Walby, Sylvia and Allen, Jonathan (2004) Domestic violence, sexual assault and stalking: Findings from the British Crime Survey (London: Home Office Research, Development and Statistics Directorate)

[21] Coordinated Action Against Domestic Abuse (CAADA) is a registered charity www.caada.org.uk/commissioning

16.1.11 Amongst the important findings in the report, the panel felt the third bullet point (exhibiting abusive behaviour) was particularly relevant to John's behaviour;

- There is a major overlap between direct harm to children and domestic abuse. Almost two-thirds (62%) of the children exposed to domestic abuse were also being directly harmed (physically, emotionally or neglected) as well as witnessing the abuse of a parent. In almost all (91%) of our cases the direct harm was perpetrated by the same person as the domestic abuse: principally their father or mother's male partner.
- Children are suffering multiple physical and mental health consequences as a result of exposure to domestic abuse. Amongst other impacts, over half (52%) had behavioural problems, over a third (39%) had difficulties adjusting at school, and nearly two thirds (60%) felt responsible for negative events.
- A quarter of both boys and girls exposed to domestic abuse exhibit abusive behaviours themselves. We found that children were more likely to show abusive behaviours after exposure to the domestic abuse had ended. Abusive behaviour was most common amongst 15 to 17-year olds. The children's abusive behaviour was most frequently directed towards their mother, sibling or friend, and rarely towards the main perpetrator of the domestic abuse.
- Worryingly, only half (54%) of the children exposed to domestic abuse, and two thirds (63%) of those living with severe domestic abuse, were known to local authority children's social care prior to intake. This is very concerning, given the evidence that two-thirds were also directly harmed, 91% by the same perpetrator. However, the great majority of these children (at least 80%) were known to at least one public agency at intake: they are in plain sight.
- Children's outcomes significantly improve across all key measures after support from specialist children's services. Our data show that specialist children's services have an immediate positive impact across all indicators of safety, health and wellbeing of children exposed to domestic abuse and direct harm.

16.1.12 The panel also felt it was relevant that this report found that abusive behaviour by a child was most frequently directed toward a mother and sibling. There were clearly parallels here in relation to the way John behaved towards Joyce, who he verbally abused, and towards Jacob's eldest daughter, who he assaulted with a knife. While some of John's behaviour could be attributed to APVA, equally the panel recognised, it

could have been attributed to his mental health condition or it could be a combination of both.

16.1.13 When completing an initial assessment of John, the case manager at Youth Justice carried out a check with children's social care. They found information about the incident of domestic abuse in 2010 and the case manager recognised this needed further exploration with John. A self-assessment completed by John outlined that his parents did argue but did not disclose any violence was used.

16.1.14 Joyce was offered family support by Manchester Youth Justice. She initially declined this, then accepted and then declined support again. There is no indication from the agency records why Joyce made this choice and the DHR has not been able to explore this issue with her. Manchester Youth Justice have identified some areas for improvement within their agency action plan in respect of the way domestic abuse is identified and responded to. While the review panel welcome these, they recognise the matters were not proximate enough to the homicide of Jacob to be a causal factor.

16.1.15 Manchester Youth Justice also identified that, from an early stage of his supervision, John indicated he wanted support to manage his anger. John received two interventions to help with this, one while he was in custody and one while he was in the community. There is also evidence from his time at College that John had been involved in incidents of violent behaviour there. This appear to have involved confrontation with peers and there is no indication from any of the records there had been violence between John and his father Jacob. However, in the light of what is now known about APVA, that behaviour could have been of some significance. Equally it could have been an indicator of deteriorating mental health.

16.1.16 During his supervision by Manchester Youth Justice the risks John presented were regularly assessed and reviewed. On most occasions he was felt to be at low risk of vulnerability and either low or medium risk of being harmed by others. None of the assessments identified that John presented a risk of perpetrating domestic abuse.

16.1.17 The DHR panel felt the assessments concerning John and the risks he presented were reasonable based upon the information then available to youth justice officers. There was no indication from any agency records that John was in a relationship nor that he had behaved in an abusive or violent manner towards his mother, father or sisters. With the benefit of

the information that is now known about APVA, such assessments would assume more significance and may need to be more in depth.

16.1.18 The first opportunity when such a risk might have been identified was the incident that occurred on 1st February 2016 (see paragraph 15.2.31). The DHR panel have carefully considered this incident and the response of GMP and the ambulance service.

16.1.19 The GMP IMR author identifies that, had the call taker correctly assessed the disturbance as a potential risk factor, it might have influenced a decision to allocate the call for immediate attendance. It has not been possible to identify why the call taker reached that decision. The text on the FWIN contains a reference to 'no disturbance' whereas, from the sounds overheard on the telephone, a disturbance was ongoing at the time the call was made.

16.1.20 Nonetheless, the IMR author recognises the call taker then demonstrated good practice by recalling the number twice and speaking to both Joyce and her eldest daughter and ascertaining further information from them. Neither of them took the opportunity to provide information that John was in possession of a weapon. Jacob's eldest daughter says in her witness statement that she told the call taker 'everything was fine'.

16.1.21 The presence of a weapon such as a knife would have escalated the risk factors very significantly. Had the police been aware of this fact it is highly likely this would have prompted an entirely different response. The DHR review panel repeat their recognition that there are many reasons why victims choose not to provide information about domestic abuse. As the DHR panel have not yet been able to speak to Joyce or her eldest daughter it has not been possible to establish why they made the choices they did.

16.1.22 The police IMR author has analysed the events thus far and identified that several significant risk factors evident in the first call from the ambulance service were not recognised by the police. These are;

- The male caller who requested the ambulance declined to identify himself but said that he was going to the house;
- The male caller said that a female had been "cut on the shoulder", the implication being that an assault had taken place and a weapon had been used;
- The ambulance service provided the police with the caller's telephone number but there is nothing recorded on the FWIN to indicate whether checks were made in police systems to identify the male caller from

that telephone number. The police system can perform this function, and this was a missed opportunity to access potentially relevant information.

16.1.23 The risk factors increased again following the second call from the ambulance service at 10.14;

- Paramedics attending the address had been refused entry;
- A female in the house spoke to the paramedics but declined to actively engage with them and appeared to not want them to look at her;
- The paramedics had expressed concerns about the incident to their own control room and wanted these concerns relaying to the police;
- The issue of whether a male was at the address was unresolved.

16.1.24 When the police contacted Joyce again by telephone at 11.23 this was a further opportunity for her to tell them the actual circumstances of the incident. Joyce again chose not to, and her reasons remain unclear. Although the information she provided was limited, the potential presence of a child in the home during a domestic abuse incident involving injuries was an additional risk factor.

16.1.25 Because Joyce said she was not available to be seen the FWIN was then delayed. The reasons included the non-availability of resources and issues in relation to the interpretation of GMP policy in relation to delayed responses. For reasons of clarity, the DHR panel do not believe it is necessary to describe each of these in detail. While they are relevant, they were not significant failings and did not directly relate to the homicide of Jacob. GMP have already taken internal action to address them.

16.1.26 When police officers attend the following day it appears they were hampered because they had not been properly briefed about the circumstances of the incident. The officers had to accept what they were told by Joyce and eldest daughter. This led to them, erroneously, believing the domestic incident involved only Joyce and her eldest daughter. Although an opportunity was missed to identify John as a perpetrator of domestic abuse, the review panel concur with the IMR author’s view that this was not the fault of the officers themselves.

16.1.27 Even if all these shortcomings had not occurred, the review panel cannot say with certainty that John would have been arrested and charged with criminal offences. Neither can the review panel conclude John would have been remanded into custody or a hospital and therefore would not have been able to harm Jacob. There are simply too many variables.

16.1.28 However, by not identifying John as a perpetrator on this occasion, opportunities were missed to consider the state of John's mental health and for him to be recorded on police systems. While the events on 15 and 16 February did not involve domestic abuse (see paragraph 15.2.46 and 47 respectively) had they been connected to the events of 1 February the police may have been able to develop a better understanding of John's deteriorating mental health and the chaos he was creating for his family.

16.1.29 No other agency held information that could reasonably have indicated there was domestic abuse within the family. Jacob was registered at a different medical practice from the rest of his family. GP contact with Jacob related to monitoring of hypertension and lifestyle advice. The only reference to his family was as part of an assessment by a specialist nurse when Jacob reported that family life was 'good'.

16.1.30 There were no issues in relation to his mental ill health. There was mention of a previous bankruptcy indicating financial problem. However, the GP records shows that latterly Jacob was employed. In February 2013 Jacob fell downstairs at home. Jacob reported this was accidental and there was no evidence to suggest that it was not as described.

16.1.31 The other GP practice, that had contact with John and other family members, held no information in respect of financial or mental health issues. The only relevant contacts were visits by John in January and October 2014 (see paragraphs 15.2.19 and 15.2.26 respectively). The first presentation related to his misuse of drugs and there were no mental health issues identified.

16.1.32 The IMR author says the GP who saw Jacob was a locum and is no longer at the practice, hence a detailed picture of that consultation cannot be recounted. Efforts to locate the GP were not successful. John and Joyce were seen separately and then together as part of the consultation. There were discussions about a range of issues including drugs, alcohol, aggression, and involvement with the police. The GP agreed to make a referral to the Alcohol and Drug services. As mentioned at paragraph 15.2.20 this happened although there is no evidence that John was given an appointment by the service.

16.1.32 The review panel felt it was noteworthy that the referral by the GP to the alcohol and drugs service referred to conflicts in the family[22]. This reinforces

[22] The GP notes use the word 'conflicts in the family' the DHR review has repeated this language because that is what is recorded. However, the DHR panel recognised that using that sort of language caused some agencies on the review panel concern as it may be another description for

the picture that emerged during contacts with other agencies such as Youth Justice and College; of a young man who was finding it difficult to coexist with his family and parents possibly because of cultural differences. This is explored in more depth at section 16.3 of this report.

16.1.33 Joyce was given advice by the GP in January 2014 to contact the police if she was worried about her safety. There is no evidence that any consideration was given to a child (Jacob's youngest daughter) being in the household and whether the issues being encountered presented a child protection issue. The IMR author says the record made by the GP demonstrated general safety advice rather than about a specific concern that required safeguarding action.

16.1.34 The visit to the GP in October 2014 was about John's perceived short-term memory issue. There were no indicators of domestic abuse during this visit. The review panel has made some comments at paragraph 16.6.4 about information sharing in respect of this visit. This was the last time John was seen in the practice.

16.1.35 The DHR review panel spent some time discussing and considering John's mental health and the way this was dealt with. The review panel drew on published information about the relationship between mental health and homicide[23]. This discloses that, during 2005-2015, 11% of homicide convictions were in mental health patients and that most patients convicted of homicide also had a history of alcohol or drug misuse; between 88% in England and 100% in N Ireland.

'In other words it is unusual for mental health patients to commit homicide unless there is a co-existing problem of substance misuse'

16.1.36 The NCI state found in their 2017 report;

'that much of the risk to others from mental health patients is related to co-existing drug or alcohol misuse rather than mental illness itself. This is an important message in combating stigma. A greater focus on alcohol and drug misuse is required as a key component of risk management in mental

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domestic abuse, particularly in the light of what is now known about APVA. When APVA or domestic abuse is present the review panel would like agencies to describe it as such rather than using euphemisms such as 'conflicts in the family'. Manchester GP practices are now IRIS trained and this includes best record keeping practice.

[23] National Confidential Inquiry into Suicide and Homicide by People with Mental Illness Annual Report 2017

health care, with specialist substance misuse and mental health services working closely together as reflected in published guidance'

16.1.37 The panel first recognised that, until he was arrested following the homicide of Jacob, John had not been diagnosed as mentally ill albeit concerns had been raised. However, he did have a history of drug misuse. That meant, had it been possible to diagnose he was mentally ill, the presence of drug misuse would have increased the risk he presented to others.

16.1.38 The panel carefully considered the different presentations of John, particularly when he was assessed whilst in police custody on 16 February 2016. The panel recognised that it can be very difficult to identify mental illness. The panel heard that people with psychosis can switch between being very florid and lucid. John was seen by a GP in January and October 2014 and by a MEDACS Health Professional while in custody. Neither of these concluded John was suffering from mental illness[24]. However, the review panel feel there was a missed opportunity for the GP to understand what was going on within the family and possibly identify some significant mental health issues (this is discussed further at section 16.6.4 of this report).

16.1.39 The panel concluded that, if there was one thing they would want to change in terms of the care and treatment John received, that would have been for John to have had an appropriate mental health assessment. The panel felt that would have been an opportunity, not just to assess the presenting condition, but rather to look at the history of John and his relationship with his family.

16.2 *How did your agency ascertain the wishes and feelings of the adults and children in respect of domestic abuse and were their views taken into account when providing services or support?*

16.2.1 The DHR panel believe that GMP responded appropriately to both reports of domestic abuse in May 2007 and December 2010. On the first occasion Joyce was offered help and support by way of a letter although the views of the children, who were present, were not sought. On the second occasion Jacob was arrested for assaulting Joyce. She did not support a prosecution and GMP respected her views and Jacob was released. The DHR panel recognise that policy has changed significantly and that currently

[24] John was not formally diagnosed with a mental illness until he was assessed in custody following his arrest for the murder of Jacob. The diagnosis reached was that John was suffering from paranoid psychosis most likely triggered off by using marihuana.

a more proactive approach might be taken in seeking the views of victims and, possibly, any children that are in the household.

16.2.2 In relation to the events of 1 February 2016, these have been analysed in detail at paragraphs 16.1.12 to 23. For reasons that Joyce and her eldest daughter have not disclosed they did not provide the police with all the information they held. Instead it appears they minimised the incidents and gave contradictory responses. Police officers followed what they clearly believed were their wishes and recorded a standard risk domestic abuse incident involving Joyce and her eldest daughter only. This meant that no further follow up was necessary. However, GMP have made some recommendations in relation to graded responses (see paragraph 16.5.2).

16.2.3 It appears to the DHR panel that the only other agency that had an opportunity to seek the views of Joyce and John, about domestic abuse was when he was placed under a supervision order following his conviction in November 2011 (see paragraph 15.2.9). On this occasion Manchester Youth Justice were proactive in seeking information from children's services. This identified that Joyce had been a victim of domestic abuse in 2010. The circumstances and detail of this have already been discussed at paragraph 16.1.7 et al.

16.3 *Were there any barriers in your agency that might have stopped the victim from seeking help for the domestic abuse?*

16.3.1 It is clear Joyce recognised domestic abuse when it happened and, as a victim, had the confidence to call the police for assistance on two occasions, in 2007 and 2010. In other DHR's it has been noted by the chair and author that victim's often reach out to the police during the immediate crisis and when it has passed are less inclined to provide details. As mentioned before in this report, because the review panel have not had the opportunity to talk to Joyce, they have not been able to establish whether there were barriers that prevented her from fully disclosing what was going on within the family in relation to John's behaviour in the few weeks before he killed Jacob.

16.3.2 The review panel took the opportunity to seek the views of Doctor Erinma Bell MBE, DL. She was asked to become a member of the panel because of the work she undertakes supporting Black and Caribbean families. Erinma is from a Nigerian family and therefore has an excellent understanding of cultural issues.

16.3.3 Erinma has never met nor had contact with Joyce and her family albeit the chair introduced Erinma to Joyce in one of his letters to her. The review panel recognise this and accepted her advice and experience. This helped them gain a better understanding of what might have been going on within the family and why some events may not have been reported to agencies rather than establishing any firm conclusions.

16.3.4 In contrast to white European families, Nigerian families remain much more patriarchal. The views of men within a household, particularly fathers, are given greater value and status. A Nigerian father would expect his wishes and instructions to be carried out and not questioned. Consequently, any refusal to do so would be regarded as disrespectful which could lead to tensions developing. For example, children who have been brought up in the UK from Nigerian parents might adopt European habits and behaviour their father considers unacceptable.

16.3.5 While families are patriarchal, mothers in Nigerian families would also expect their children to behave in a respectful manner towards them. Any challenges, refusals or argumentative behaviour would be regarded as disrespectful and distressing. However, in response to that behaviour mothers would not willingly give their children up to the authorities. Similarly, they would be reluctant to report their spouses to the authorities. They would rather try to resolve issues in other ways. Consequently, they would be much more likely to seek help from voluntary rather than statutory services.

16.3.6 As a developing country, Nigerian fathers and mothers have a strong desire to see their children thrive in their academic studies and careers. Parents may have strong views about academic or career pathways which might not accord with their children's wishes. A failure, perceived or real, to achieve good results may well cause tensions between parents and children. There is some evidence for this when John told staff at College that his parents had high expectations for his academic achievements.

16.3.7 Nigerian families also have a very strong sense of pride in the family. Mothers and fathers are likely to have very real concerns about events that might be perceived as bringing shame upon their family. Hence there might be a fear of reporting or involving agencies in events which could potentially lead to the family being exposed to embarrassment.

16.3.8 The DHR panel recognise the possibility that these cultural factors may, or may not, have played some part in presenting a barrier to Joyce and her family in being more proactive in seeking help to cope with John's

behaviour. However, without having spoken to Joyce the panel feel unable to reach any firm conclusions and simply suggest them as possibilities. The panel did however feel it was noteworthy that some of the cultural issues and the fears of families in reporting APVA are also recognised within the Home Office information booklet about this matter.

16.4 *What knowledge did the family, friends and employers have of the adults' relationship, that could help the DHR Panel understand what was happening in their lives; and did family and friends know what to do with any such knowledge?*

16.4.1 It is clear Joyce and her eldest daughter had considerable knowledge about the declining relationship between John and his father and this is set out earlier in section 13 of this report. Other family members who lived nearby also provided information to the homicide enquiry about John's behaviour. A relative recalls some months before Jacob's death, seeing John at a family party when he did not look himself and was 'just stood staring'. Jacob's eldest daughter told this relative that John had been 'rude' at home. John later visited this relative and started to say strange things.

16.4.2 Following the events of 1 February 2016 (see paragraph 15.2.31) Jacob's eldest daughter telephoned the same relative. She told them she had been stabbed by John. Shortly afterwards John arrived at the same relative's house asking to be let in: he was refused entry. John then exchanged a series of text messages with this relative. When asked why he had stabbed his sister he said it was elder sister that stabbed him, and he was retaliating. He then said that his eldest sister was not really his sister. John asked for help and was told by the relative that if he did not leave the police would be called.

16.4.3 On 15 February 2016 Jacob's eldest daughter exchanged a series of text messages with the same relative and described the incident that happened that evening including the attendance of the police (see paragraph 15.2.46). Jacob's eldest daughter exchanged further texts in the early hours of the following day. In the text messages sent on 16 February Jacob's eldest daughter described how John was back at the house again and had assaulted Jacob who had tried to defend himself. The relative sent a message to Jacob's eldest daughter saying that her parents should call the police again and they should tell them this was an assault.

16.4.4 In further texts Jacob's eldest daughter describes how her parents had then let John into the house. The relative expressed concerns, and again, said the police should be called. Jacob's eldest daughter then told the relative

that the family were planning to leave the house the following day and stay with another relative.

16.4.5 At that point the first relative offered to come to the family home in a taxi. When they arrived, they spoke to Jacob who told them John had punched him. Jacob, Joyce and the two daughters then got in the taxi, left the family home and went to stay with the relative for two days. When they returned to the family home the relative remained very worried about the family.

16.4.6 It appears to the review panel that the advice of the family member, to call the police, was the appropriate course of action. While the police had already attended before that advice was given, they did not take any action against John as it did not appear the police officers knew that John had committed any substantive offences that night for which he could be arrested. A second call to the police would have provided an opportunity to arrest John, who by this time had assaulted Jacob by punching him. This would have provided a chance to assess the risks John posed and obtain a full picture from the family about his behaviour. Again, the DHR panel are not able to establish why the family did not take the advice of the relative and call the police.

16.5 *Were single and multi-agency policies and procedures followed; are the procedures embedded in practice and were any gaps identified?*

16.5.1 GMP identified policies to address domestic abuse were in place at the time and were followed in relation to the reported domestic abuse incidents in 2007 and 2010 (see paragraphs 15.2.1 and 15.2.5 respectively). Based upon the information known to the police, the officers dealing with the events on 1st February 2016 correctly followed the current policy (2015) in respect of domestic abuse.

16.5.2 As set out in 16.1.21 there were some breaches of the GMP policy in relation to graded response. This matter has already been referred by the IMR author in a separate report, to the Chief Superintendent in charge of the Operational Communications Branch to highlight individual and organisational learning. For that reason, the incident is not subject of any recommendations in this report.

16.5.3 Manchester Youth Justice identified there were indications that Joyce had been subject to domestic abuse from her husband. John did not disclose that he had been a victim or perpetrator of domestic abuse however he did have anger management issues. Within his Risk Management Plan a referral

should have been made to 42nd Street[25] for anger management. There is no evidence that was followed up. However, John did receive two anger management interventions, one in custody and one in the community.

16.6 ***How effective was inter-agency information sharing and cooperation in response to the subjects' needs and was information shared with those agencies who needed it?***

16.6.1 GMP shared information concerning the domestic abuse incidents in 2007 and 2010 with health visiting and Children's Social Care (see paragraphs 15.2.1 and 15.2.5 respectively). It appears this was effective in as much as it helped inform the assessment carried out upon John by Manchester Youth Justice (see paragraph 16.1.7). In turn this led to questions being asked of John about his knowledge of domestic abuse within the family. It also led to Joyce being offered support.

16.6.2 College identified that John had potential mental health needs (see paragraph 15.2.3). While they did not make a referral to mental health services, staff from the college did discuss concerns with Joyce and encouraged John to visit a GP. They also encouraged John to seek support from counselling in the college and an African/Caribbean mental health support group. That showed good knowledge of a specialist group.

16.6.3 As John was successful in securing a place at University, the panel asked College whether they had considered sharing information about their concerns for John. The safeguarding officer from the College said they did not, for two reasons. Towards the end of his College programme John's performance had improved and he was successful in completing the programme. The second reason was that there is no platform or protocol for sharing such information. UCAS[26] do not have a facility for sharing such information and, as students can apply for multiple Universities, their host institution would not know at the time where the student was moving to.

16.6.4 While there is no process for further education colleges to share information, the safeguarding officer said that College are part of a network

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[25] 42nd Street supports young people aged 11-25 years in Manchester with emotional wellbeing and mental health. They offer a range of individual therapeutic support and encourage and support young people to have a voice, and access opportunities to learn, develop new skills, be creative, have fun and demonstrate to themselves and others that they are able to recover, manage their mental health and wellbeing and achieve their full potential. They deliver services from a Manchester city centre base, in community venues, arts and cultural centres, and in schools and colleges.

[26] (UCAS)The Universities and Colleges Admissions Service is a UK-based organisation whose main role is to operate the application process for British universities.

linked to safeguarding and Prevent[27] that are engaged in developing a process for sharing information. Had the university to which John was applying approached College with concerns (if they had any), then the College would have considered sharing information with them had John consented.

16.6.5 The panel discussed the role of the college in sharing information with the GP or whether the college should have shared information directly with the GP. John had attended the GP due to concerns raised by the college. He told the doctor about problems with his memory. John was asked to obtain a letter from the college outlining their concerns so that he could review whether a referral was needed. Panel members discussed whether this was appropriate and whether the GP should have spoken directly to the college.

16.6.6 Panel members discussed whether there might have been a missed opportunity for the College to make an adult safeguarding referral, particularly when they had considered John to be a risk. It was noted that the college had supported John, however he didn't always engage, and a multi-agency coordinated response might have worked better.

16.6.7 The panel felt that it would be useful to understand more about the Child and Adult Safeguarding Policies and Procedures at the college and whether these were followed. The panel therefore retuned to the college and asked them if they could provide more information. The college stated that their concerns for John's mental health were ongoing. They tried to get him the best support they could through internal mechanisms such as the counselling service and student support pastoral team; by trying to get John to see his GP; to speak to his mother and to get in contact with the African/Caribbean Mental Health Team.

16.6.8 The college state that John did not engage, however after a short time he did show good progress until the incident on 29.04.2015. In relation to why a referral was not made to Adult Safeguarding, the college state this was because John had no learning difficulties on record and this would previously have been one of the considerations to escalate matters under adult safeguarding proceedings. The review panel feels, that if concerns for the welfare of others continue, then agencies should still make a safeguarding referral or contact the police.

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[27] Prevent is one of four work strands which make up the government counter-terrorism strategy. The aim of Prevent is to stop people becoming terrorists or supporting terrorism.

16.6.9 Since these events and following the Care Act 2014[28] coming into effect in April 2015, the college has updated its safeguarding policies. Training has also been undertaken to reflect any changes. The DHR review panel concluded that, the fact College did not make an adult safeguarding referral in 2015 in relation to John, was reasonable given the policies then in place.

16.6.10 There is no evidence John visited a counsellor nor the support group. However, John did visit his GP with Joyce. The Mini Mental State assessment carried out by the GP did not identify any significant issues and the GP asked John to obtain a letter from the college articulating their concerns. There is no evidence John ever asked the college for this letter.

16.6.11 Manchester Youth Justice made a referral to GMP for John to be included on the Integrated Offender Management (IOM) cohort as part of his licence conditions. IOM brings a cross-agency response to the crime and reoffending threats faced by local communities. The most persistent and problematic offenders are identified and managed jointly by partner agencies working together. Placing John on the IOM cohort ensured that he remained in contact with criminal justice agencies who would closely monitor his behaviour and respond swiftly to any indicators that he may have been re-offending. The DHR panel felt this was good practice.

16.6.12 The GP IMR author identified that GP records showed there were some difficulties in the family in relation to John's period of detention (see paragraph 15.2.9 et al). However, there was nothing in the GP record that identified the circumstances surrounding this. The only information supplied to the GP was on discharge from the detention centre. The IMR author feels it would have been potentially beneficial if more detailed information regarding John's sentence had been provided and this might have given the GP a better picture of John during the consultation in January 2014.

16.6.13 The GP IMR author has also identified that notifications GPs receive from accident and emergency departments offer no detail on how patients come to receive their injuries or the circumstances around these. The author believes it would be helpful for the circumstances regarding the presentation to be documented on the notification sheets to enable the GP to have a fuller picture in terms of any potential safeguarding issues. They have identified this within their agency action plan (see appendix A)

[28] Under the Care Act, local authorities have new functions. This is to make sure that people who live in their areas: receive services that prevent their care needs from becoming more serious or delay the impact of their needs; can get the information and advice they need to make good decisions about care and support; have a range of provision of high quality, appropriate services to choose from.

16.7 *How did your agency take account of any racial, cultural, linguistic, faith or other diversity issues, when completing assessments and providing services to the subjects?*

16.7.1 Issues of equality and diversity have already been considered at section 11 of this report and are therefore not repeated here. Save for one agency, [College] who directed John to a culturally appropriate agency] there is no specific information in any agency records that suggests how practitioners took account of specific racial, cultural, linguistic, faith or other diversity issues. That is not to suggest they did not do so, simply that there is nothing recorded to provide insight into this area.

16.7.2 The area of Manchester where the family lived is a multi-ethnic, racially and culturally diverse area; as is the borough where John attended college. Practitioners in both those areas are experienced at recognising and implementing engagement practices within that community. The review panel has not seen any evidence to indicate that, because of diversity issues, the service any members of the family received fell below the expected standard.

16.7.3 All the agencies contributing to this review have policies in place designed to ensure the service they provide meets the needs of a diverse population. Any shortfalls that have been identified, based upon the information available, appear unconnected to diversity issues.

16.7.4 The DHR panel are grateful for the advice they received from Doctor Erinma Bell MBE, DL about specific cultural issues within the Nigerian community that may have raised barriers to the family engaging with agencies. However, at this stage, the review panel is not able to reach a conclusion as to whether there was a correlation between the two issues.

16.7.5 The panel discussed the role of the church and religious communities in resolving issues within a family. The panel understand Joyce and her daughters attended church regularly. They do not know whether Jacob or John attended church or whether Joyce ever disclosed problems to the church; including problems with John or domestic abuse.

16.7.6 Dr Erinma Bell DL explained that, in her experience, many people will speak to the pastor and their wife who usually plays a large role. However, some churches will not always respond appropriately to things such as disclosures of domestic abuse. In Dr Bell's experience, some churches will advise people to return to their husband and resolve things through prayer.

16.7.7 While the review panel recognised that it does not know whether or not Joyce ever made a disclosure to the Church they felt it was important to recognise the role Church and other faith-based groups can play in helping victims deal with their victimisation. To protect victims and reduce the risks they face the panel felt it was vital that churches and faith groups should follow safeguarding procedures. The panel felt there was a need to ensure that all churches and faith-based groups linked in to the safeguarding processes in their local authority area and understood and abided by their obligations. That could mean, when necessary, engaging with reviews such as this.

16.7.8 The panel also discussed domestic abuse in hard to reach communities. They were reassured by a briefing from the policy specialist from Manchester City Council (who was a member of the DHR panel) that the domestic violence and abuse action plan already contains some specific actions about reaching out to communities. Work has commenced which includes reaching out to all community groups faith organisations and residents fora etc. This reach out will also involve briefings and literature, so they know who to contact and how to access advice and support. Manchester City Council has also run targeted communications campaigns to raise awareness of domestic violence and abuse.

16.8 *How effective was your agency's supervision and management of practitioners involved with the response to needs of the victim and perpetrator and did managers have effective oversight and control of the case?*

16.8.1 The incident on 1 February 2016 is analysed in detail at paragraph 16.1.12 et al. There were some failings on the part of control room supervisors and opportunities for organisational learning arising from this incident have already been highlighted by the IMR author in a separate report to the Head of the Operational Communications Branch within GMP.

16.8.2 The police IMR author has considered whether supervisors could have recognised that John may have had mental health issues when he was arrested on 16 February (see paragraph 15.2.47). John was subjected to an assessment of his suitability to be detained, he was seen by a MEDACS medical practitioner, his detention was reviewed on several occasions and he spoke to a legal advisor by telephone. None of these raised any concerns or identified any additional needs around mental health vulnerability.

16.8.3 Based upon what the police knew, and what was available for them to find out, the review panel conclude those dealing with John while he was in

custody acted reasonably. While the IMR police author has not made any recommendations specific to this review around mental health, they have identified that GMP, in conjunction with partner agencies and the Police and Crime Commissioner has already embarked on a wide ranging educational programme addressing all aspects of mental health awareness including the recognition of symptoms[29].

16.8.4 Although Manchester Youth Justice identified evidence of some management oversight in respect of John's risk management plans this was not as thorough or effective as it should have been. At the time John was supervised by the agency there was no clear policy on management oversight setting out how that should be carried out and what it should focus on. The review panel do not believe that any of the gaps in management were significant nor were they contributory factors to the homicide of Jacob.

16.9 *Were there any issues in relation to capacity or resources within your agency or the Partnership that affected your ability to provide services to the victim?*

16.9.1 The incident on 1 February 2016 (paragraph 15.3.16) was assessed as requiring a grade 2 response. The rationale and processes around that assessment are discussed in detail at section 16.1 et al.

16.9.2 A grade 2 response meant that police officers should have attended within one hour of the call. The response time was not met, and police officers did not attend and speak personally to Joyce and her eldest daughter until 28 hours later. While there are other factors that influenced that delay, high demand and/or reduced resources were significant issues that affected the ability of GMP to respond appropriately to this incident. The police IMR author believes the incident highlights the type of resourcing and capacity issues the force faces every day.

16.9.3 Similarly, the availability of police resources may be a factor in John being released without interview after 12 hours in custody (see paragraph 5.3.39). The IMR author identifies that responsibility for concluding the investigation was delegated from the original arresting officers to different officers to avoid officers being retained on duty and incurring overtime.

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[29] Police launch pilot scheme to enhance mental health support.
http://www.gmp.police.uk/live/nhoodv3.nsf/36d69ab4a7a24df280257db0003e60c7/5e4266c278beb03d80257d3c0047ad63!OpenDocument

16.9.4 The investigation was never completed; no statements were taken from the owner of the vehicle or staff at the garage and neither was John interviewed. The IMR author concludes that police practice on this occasion was ineffective and the reasons for this remain unclear.

16.9.5 The review panel recognise the deployment of limited police resources and budgetary decisions concerning overtime are entirely operational matters for the Chief Constable of GMP. However, the panel does not believe these factors contributed in any way to the homicide of Jacob.

17. Conclusions

17.1 Jacob and Joyce had been settled in the UK for many years. Jacob was Nigerian by birth and Joyce, while born in the UK, had lived in Nigeria for several years. It appears they still had very strong family and cultural links to Nigeria. Joyce and her daughters worshipped at a local church and appear to have been active members of that community.

17.2 The review panel has not been able to engage with Joyce as she does not feel ready to talk about these tragic events. The panel know that some of the most important learning from domestic homicide reviews is gleaned from families. However, the panel recognises how difficult this must be for Joyce and accepts her choice that at, this time, she does not feel ready to engage with them. The panel continues to extend its invitation to Joyce to share her thoughts and feelings in the hope that her, and her family's, sad experience might help other families who find themselves in a similar situation.

17.3 In the absence of Joyce's contribution the DHR panel do not feel able to reach any firm conclusions as to what was happening within the privacy of the family at the time John became ill and killed his father. Neither do the review panel feel able to reach any conclusions as to why Joyce, her eldest daughter or other family members did not engage with agencies nor disclose all they knew about John's behaviour in the last few weeks of Jacob's life.

17.4 What the panel can conclude with some certainty is that John had misused cannabis for some years. As a young person he appears to have been an outstanding achiever at school. However, around late 2011 his behaviour changed. In a very short period he committed very serious offences for which he received a custodial sentence. The panel cannot be certain as to what drew John into that cycle of offending; the possibility exists that it could have been misuse of cannabis or the influence of the other youths he offended with.

17.5 Joyce had reported two instances of domestic abuse to GMP. When John engaged with Manchester Youth Justice they identified, through information sharing, that domestic abuse had occurred in the household. Two self-assessments were completed with John and a home visit was made specifically to offer family support to Joyce. However, no disclosures were made by John.

17.6 The panel has recognised within their report the information that is now emerging about APVA. They believe the way John behaved towards his mother, sister and father could be examples of APVA or equally they could also be examples of deteriorating mental health or both. They also recognise there may be links between APVA and an adolescent having been exposed

to domestic abuse. Agencies need a better understanding of APVA and ensure their policies and procedures recognise its existence and steps needed to protect victims and ensure those who perpetrate abuse as an adolescent receive appropriate interventions.

17.7 During the time he engaged with Youth Justice, John recognised that he had anger management needs for which he sought help. He received two interventions for his needs and was also referred to specialist services to help manage his misuse of cannabis which was identified as a factor in the decline of his relationships at home and his academic performance.

17.8 When John successfully completed his period of supervision on licence and his treatment plan, there should have been every prospect that he could get back on track and successfully complete his education. In fact, John did not have contact with criminal justice agencies again for sixteen months. Unfortunately, his behaviour did change. Joyce suspected John was using cannabis and obtained a test kit which returned a positive result.

17.9 Joyce sought help from her GP. The GP made a referral to specialist services to deal with John's misuse of drugs. The referral letter described some conflict in the family and John told the GP there were arguments with his parents regarding differences in attitude to lifestyles. Unfortunately, the referral to specialist services was not received and hence an opportunity was lost to re-engage with John and potentially to illuminate and address what was happening within the family. The panel have not been able to identify why that did not happen.

17.10 It is clear John's misuse of cannabis continued as GMP detained him in possession of cannabis on two occasions-in October 2014 and April 2015. It is unclear whether Joyce or Jacob was aware of these events and, if so, what impact they had upon family life. If they had discovered, it could have increased tensions between them and John significantly. Despite appearing to have potential, John's record of attendance and performance at College was poor. The college clearly tried hard, they did not give up on John and made great effort to get him back on track.

17.11 The college recognised that John was displaying behaviour that might indicate he had mental health issues and they encouraged him to visit a GP. They tried to get John to see a counsellor and a specialist service for African Caribbean mental health. The college also contacted Joyce which prompted an appointment to be made with the GP. Unfortunately, John did not follow the GP's request of obtaining a letter from the college articulating their concerns.

17.12 John was never seen again by the GP. Neither did the GP appear to make any connections between that visit and John's previous presentation to another GP at the practice concerning his misuse of cannabis. The panel believe these were missed opportunities to understand and intervene in John's declining mental health. The panel felt that, ideally, John should have undergone a full mental health assessment. Consideration of the wider issues, rather than the narrow presenting issues, may have helped illuminate what was happening within the family.

17.13 John's use of a knife to attack his sister was a significant and dangerous escalation in either his abuse behaviour or his mental health or possibly both. She, and others in the family were clearly at risk. The police and an ambulance were called. The ambulance attended although Jacob's eldest daughter declined treatment. Unhappy with the incident the ambulance crew requested the police carry out a welfare visit. Unfortunately, neither Joyce nor her eldest daughter disclosed all that had happened either in telephone calls or when they were visited by the police over a day later. Although there were shortcomings in the application of the police attendance policy, the lack of information from Joyce and her eldest daughter was a significant factor in the police not recognising the real nature and seriousness of the incident. Professionals would have recognised the escalation, whereas the family may not have understood its significance and the importance of sharing the detail with the police so they could address the increased risk John posed.

17.14 Jacob's eldest daughter explained in her witness statement that she was shocked. As the panel has not been able to engage with Joyce they do not have her explanation. The review panel cannot reach a conclusion as to why important information was not passed to the police, and instead reiterate what has been said earlier in this report that there are many reasons why victims choose not to disclose abuse (see footnote 12).

17.15 John's challenging behaviour continued, and the police were called to the family home again on 15 February when Joyce refused to let him back in. Had the connection been made with the previous events on 1 February then this might have been a further opportunity to address the risk John posed. However, the officers attending would have had no knowledge as to John's involvement in that event. They simply carried out Joyce's request, which was to remove him from the front of the house to prevent a disturbance.

17.16 During the early hours the following day John returned to the house and after a disturbance at the front door he assaulted Jacob. This is the only occasion before Jacob died there is evidence John used force on his father. Again, this marked a further escalation in John's behaviour and the risks he posed. Another family member encouraged them to call the police: instead

Jacob, Joyce and their two girls left and sought sanctuary with the family member. The review panel do not know why Jacob and Joyce chose not to contact the police. It would have presented another opportunity to identify and address the risk John posed and, with evidence of a substantive offence (the assault on Jacob), might have possibly led to John being detained and charged.

17.17 John's arrest the following day, when he was found in a car at a garage, did not directly involve Jacob and Joyce and it is unclear as to whether they ever became aware. While it did not involve domestic abuse, his behaviour at the scene of the offence was 'strange' and this did present an opportunity to assess his mental health. That happened when his suitability for detention was assessed. He was also seen by a medical practitioner and his detention reviewed on several occasions. No concerns were recorded in relation to his mental health and he was released from custody.

17.18 The DHR panel recognise the difficulties in assessing mental health, particularly by those who are not health professionals. While the DHR panel make no criticism of the police officers or staff that dealt with John on this occasion they welcome the information supplied by GMP as to the very positive steps they have taken in increasing knowledge within the force about mental health issues.

17.19 There is no independent evidence as to what triggered the fatal attack John made upon Jacob. The panel can only raise possibilities. There was clearly a decline in John's mental health and this was most probably linked to his use of cannabis. His later diagnosis of paranoid schizophrenia helps explain his often-bizarre behaviour.

17.20 It is possible that Jacob was becoming very frustrated with the behaviour of his son. Joyce told the police that she had asked Jacob not to confront John until he got help. It is possible that, for cultural reasons, Jacob felt he had every right and possibly a duty, to try and get his son back on the right track. The review panel do not know what triggered the chain of events that morning that ended with Jacob's death: while there are only possibilities that morning, none of these presented opportunities for agencies to directly intervene.

17.21 While there is some organisational learning arising from this review there were no significant failures in the way that agencies responded. Whatever tensions there were, there can be no excuses for what John then did by attacking his father with a knife. However, it has to be remembered that John was mentally ill. Jacob will be missed by his family. The review panel

concludes by extending their sympathies to them and all who knew or cared about Jacob.

18. LESSONS IDENTIFIED

18.1 Agencies Lessons

	GP Medical Practices
1	A greater degree of professional curiosity in October 2014 could have prompted a discussion to check if the previous issues, especially those around potential conflicts in the family and drug use, had been resolved or were still on-going.
	Manchester Youth Justice
1	The importance of gathering information about a family from other sources to inform an assessment.
2	When there are indications of domestic violence, these should be investigated further and be referred to in subsequent assessments.
3	Management oversight needs to be more effective.
4	Supervision has been focused on the young person and not taken enough account of the wider family context.
5	Appropriate Referrals need to be made promptly and followed up.
6	Practitioners need better awareness of signs of domestic abuse within the home.
7	To strengthen family work within the Youth Justice Service.
GMP	
1	Resourcing and responding to incidents where vulnerability risks are evident.
2	Recognition of mental health indicators.
3	Barriers to reporting domestic abuse

18.2 The Domestic Homicide Review Panel's Lessons

18.2.1 The DHR panel identified the following lessons. The panel did not repeat the lessons already identified by agencies at paragraph 18.1. Each lesson is preceded by a narrative which seeks to set the context within which the lesson sits. When a lesson leads to an action a cross reference is included within the header.

Lesson 1 (Agency recommendations 2, 3, 4 & 6)
Narrative
Joyce was a victim, parent and mother and wanted to deal with family matters privately including John's abusive behaviour. Beyond the apparent cultural reasons, the panel have not been able to explore why. However, they accept that is the way some parents will respond to a crisis in their family. After a mini-mental health assessment the GP who saw John and Joyce asked him to return to College and obtain a note detailing their concerns.
Lesson
Recent information from the Home Office[30] recognises that in situations like this, for a range of reasons, parents may be reluctant to discuss the abusive behaviour of a child or young person. The GP who spoke to Joyce and John could have had a broader conversation with them to try and identify what was happening within the family.

Lesson 2 (Panel recommendation 1)
Narrative
Many of the behaviours that John displayed, and the dynamics within the family, were characteristic of Adolescent to Parent Violence and Abuse (APVA) though they could also have been symptoms of his deteriorating mental health. While agencies responded to individual events, there appeared to be no recognition of the need to gain an understanding of the pattern of John's behaviour.
Lesson
Agencies and professionals need to gain a better understanding of APVA, where necessary incorporating information about and the advice about how to respond into their safeguarding policies. There may be a similar lack of understanding among the wider community.

[30] Information guide: adolescent to parent violence and abuse (APVA) Home Office

Lesson 3 (Panel recommendation 2)
Narrative
John was seen by a GP, by police officers and by a MEDAC Health Professional none of whom identified that he may have been suffering from a mental illness. A short time after he was last seen while in custody he killed Jacob. Following his arrest John was assessed by a mental health clinician as suffering from mental illness-paranoid psychosis most likely triggered off by using marihuana.
Lesson
People with psychosis can present with many different behaviours. Therefore, professionals may come up with different conclusions. People displaying behaviours like John need pathways that ensure they are referred to appropriate specialist mental health support if they are not accessing support via their GP.

Lesson 4 (Panel recommendation 3)
Narrative
The panel do not know whether the church Joyce and her daughters worshiped at knew about the behaviour of John and the concerns within the family. The panel tried to engage with the church and they were unresponsive. Consequently, the panel do not know to what extent the church has embedded safeguarding within its work.
Lesson
Joyce had an absolute right to deal privately with family matters. However, churches and faith communities are often places where victims and families feel may seek advice and make disclosures. It is therefore important that churches and faith communities have policies in place that recognise domestic abuse (including APVA) and understand what to do if they receive a disclosure.

19. RECOMMENDATIONS

19.1 Agencies Recommendations

19.2 The Panel's Recommendations

Number	Recommendation
1	Manchester Community Safety Partnership ensure all partner agencies are briefed about the issues of APVA. Partner agencies to ensure their policies and procedures incorporate the most recent guidance about how to respond to APVA.
2	Manchester Community Safety Partnership and Manchester Safeguarding Board to ensure partner agencies have safeguarding procedures in place that are compliant with the Care Act 2014 and that safeguarding referral pathways are in place where concerns are identified.
3	Manchester Community Safety Partnership to work with the Manchester Adult Safeguarding Board to assure themselves that all churches and faith communities understand their obligations in relation to domestic abuse and APVA safeguarding and receive advice and guidance as to the policies and practices they should have in place to deal with these matters.
4	Manchester Community Safety Partnership should assure itself that referral pathways are in place where there are concerns regarding a person's mental health and they do not appear to be accessing support from their GP or a specialist mental health service. Greater Manchester Mental Health should ensure that such referral pathways are promoted across the partnership.