SaferWalsall Partnership

working together for a safer borough

Domestic Homicide Review

Under section 9 of the Domestic Violence, Crime and Victims Act 2004

In respect of the death of Francis in August 2019

DHR 9

Report produced by Simon Hill
(Independent Chair & Author)

June 2021

I would like to begin by saying Francis and myself had been married for a long time and had two wonderful sons.

To most people we were just a normal family. We had our own touring caravan which we took advantage of most weekends and school holidays and the lads loved being on caravan parks and meeting new friends.

Circumstances in life happen and each individual deals with crisis better than others. In the latter years of our marriage, we seemed to have more than our fair share of emotional distress and Francis' way of dealing with it was to be found at the bottom of a glass. Unfortunately, under the influence of alcohol his mood changed, he became argumentative, non-co-operative and verbally abusive to whoever crossed his path.

When Jesse left university, he had his own demons in his life which escalated his mental health condition and life became very difficult at home.

Jesse and his dad had a love-hate relationship, fighting one minute and hugging each other the next. They were two peas in a pod, they couldn't live together, and they couldn't live apart. This became quite apparent following his dad's death.

The fallout on the evening which resulted in Francis' death was just another argument that happened on a regular basis, especially if alcohol was involved. Generally, the arguments were in the house and me in between them trying to break them up!

The tragedy of that dreadful night was that it happened outside in the garden and the risk of injury was far greater.

From that evening my life changed forever I not only had to cope with the loss of my husband but also the torment and deterioration of my son's mental health because of it. It destroyed him, resulting in his suicide exactly one year to the date of the altercation.

One stupid argument over two cans of lager resulted in two deaths and the people they left behind completely and utterly devastated.

Hazel, June 2021

The Safer Walsall Partnership and Domestic Homicide Review panel and Independent Chair would wish to express sincere condolences to Hazel and her family and friends for the loss not only of Francis but also of Jesse given the tragic circumstances surrounding both deaths.

CONTENTS

1 The Review Process

1.1 Timescales for the review

1.1.1 At its meeting on the 10 October 2019 Walsall Council's Performance Review Group established that the criteria for a Domestic Homicide Review (DHR) had been met. This decision was subsequently confirmed by the Safer Walsall Partnership (SWP) Board at its meeting on 22 October 2019 and the review into this case commenced thereafter. The SWP appointed an Independent Chair on 5 November 2019 and identified a DHR panel.

1.1.2 The DHR experienced some delays caused by the redeployment of staff and the demands upon CCG, NHS Trusts and Police, of responding to the COVID-19 pandemic.

1.1.3 There was an additional impact upon the DHR, caused by the delay to Criminal Trials during 2020 and the consequential inability to hold family conversations. The criminal process ended when the perpetrator, Jesse, sadly took his own life in August 2020, on the anniversary of the homicide. The DHR therefore allowed the family to determine when they felt able to engage with the DHR.

1.2 Confidentiality

1.2.1 The Safer Walsall Partnership maintained the confidentiality of this Review throughout the process. Information was shared only with Panel members, Individual Management Review (IMR) authors and agencies restricted disclosure of any shared information to those key staff participating in the review.

1.2.2 Following consultation with the family, the family's names were chosen by them to provide anonymity:

- Francis (the victim): 65 years old at the time of the homicide. His ethnicity was white (English).
- Hazel: Francis's wife and mother of Jesse and Arno.
- Jesse (the perpetrator): 25 years old at the time of the homicide. His ethnicity was white (English).

- Arno: Francis and Hazel's son
- Lizzy: Jesse's girlfriend in Lincoln (2014-2016)
- Chloe: Jesse's girlfriend in Lincoln (2017-18)
- Anika: Jesse's girlfriend (2019-20)

1.3 Methodology

1.3.1 On the 22 October 2019 the Chair of the Walsall Community Safety Partnership determined that in relation to the homicide of Francis, the criteria for holding a Domestic Homicide Review (DHR) under Section 9 of the Domestic Violence, Crime and Victims Act 2004 had been met.

1.3.2 The SWP conducted a scoping of agencies that may have been involved with the subjects of the Review and identified agencies in Walsall but also in Lincolnshire, where the perpetrator attended university, and in Cornwall, where Jesse worked for a period. Although Jesse worked in Prague, Czech Republic, for a few months, it was not felt that the DHR remit could extend to agencies outside of the UK.

1.4 Involvement of family and friends

1.4.1 The family were written to by the Independent Chair at the start of the DHR process and the Home Office leaflet outlining the DHR process was shared. They were assured that they could engage with the DHR through whichever medium they chose or could decline to be involved.

1.4.2 The DHR Chair was gratified to be able to hold a detailed virtual conversation with the victim's wife, Hazel, who provided valuable insights into the lives of both the victim and the perpetrator, her son.

1.4.3 Hazel has been supported throughout by a West Midlands Police Family Liaison Officer and also by an advocate from Victim Support Homicide Service, as well as from Hundred Families.[1] The DHR Chair liaised with the Victim Support Homicide Service advocate to identify when Hazel would feel able to engage

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[1] Hundred Families-aims to offer accurate information and practical advice for families bereaved by people with mental health problems.

with the DHR and shared updates with the family as appropriate. The DHR Chair spoke in a virtual meeting with Hazel and Anika (Jesse's girlfriend in 2019-20) in November 2020 (Victim Support Homicide Service and Hundred Families advocates joined the conversation) and Anika alone in December 2020.

1.4.4 The Overview Report was shared with the family for comment and amendment prior to final completion, before it was reviewed by the Responsible Authority.

1.5 Contributors to the review

1.5.1 IMRs were required from the following agencies:

- West Midlands Police
- Walsall Clinical Commissioning Group
- Walsall Healthcare NHS Trust
- Dudley & Walsall Mental Health Trust (now the Black Country Healthcare Foundation NHS Trust)

Additional information was sought from other agencies that provided helpful reports responding to the panel's specific questions:

- Lincolnshire Police
- The University of Lincoln Health Service
- University of Lincoln Student Wellbeing Service
- United Lincoln NHS Hospital Trust
- Lincolnshire West CCG
- NHS Kernow CCG

1.6 The review panel

Name	Role	Organisation/agency
Simon Hill	Independent Chair and Overview report writer	-
Susan Dicks (Ian Billham from June 2020)	Interim Head of Community Safety	Walsall Council, Safer Walsall Partnership
Richard Bridgeman (Vinny Parsons from June 2020)	Not known Detective Sergeant	West Midlands Police

Andrew Colson (Christine Harris from February 2020)	Quality, Adult Safeguarding Lead Interim Designated Nurse Adult Safeguarding	Walsall Clinical Commissioning Group
Sharon Latham (Kudzi Mukandi from February 2021)	Head of Safeguarding	Dudley & Walsall Mental Health Trust
Jennifer Robinson	Lead Nurse Safeguarding Adults	Walsall Healthcare NHS Trust
David Neale	Programme Development & Commissioning Manager	Walsall Council, Public Health
Craig George	Investigations Manager	Walsall Council, Money/Home/Job
Sarah Barker	Business Manager	Walsall Council, Safeguarding Partnership Business Unit
Support Officers		
Jane Murray	Project Manager	Walsall Council, on behalf of Safer Walsall Partnership

1.6.1 The DHR panel members were independent of the case and none had had any involvement with any of the parties subject to the DHR.

1.6.2 Panel meetings were held on 11th December 2019, 25th February 2020, 15th June 2020 (virtual), 3rd September 2020 (virtual) and 9th February 2021 (virtual).

1.7 The overview author

1.7.1 The DHR Chair/Overview author Simon Hill is a retired West Midlands Police officer, who served for a number of years on the Public Protection Unit, investigating both child and adult protection cases. He was never involved in safeguarding decisions in the Walsall area, being based in Ladywood and Central Birmingham. For five years he was responsible for the Review Team contributing IMRs to SARs, Safeguarding Child Reviews and Domestic Homicide Reviews.

1.7.2 He has conducted numerous DHRs and SARs around the West Midlands region in the last eight years. He regularly presents learning from SARs and DHRs at events held by Safeguarding Partnerships as well as facilitating multi-disciplinary workshops. For the last four years he has provided level III Adult

and Child Safeguarding training for Black Country CCGs and hospital and Mental Health Trusts.

1.7.3 He has had no involvement with any of the events that were the subject of the review and was no longer serving as a police officer during the period under review, and is therefore independent of any police involvement described in this case.

1.8 Equality and diversity

1.8.1 The DHR did not identify any relevant equality and diversity issues in relation to the nine protected characteristics under the Equality Act 2010. The victim Francis was a 65-year-old male, and his ethnic origin was white, English. He had worked in local government and apparently accessed primary care and health services. It appears that he had identified his vulnerability in relation to Jesse and had discussed this with the practice manager and doctors at his GP practice.

1.8.2 It is however very possible that as a male he did not see himself as a potential victim of domestic abuse. Similarly the response of his GP's practice when he identified anxieties concerning potential abuse from his son seemed to show a degree of gender bias; advising Francis to speak to the police, rather than offering appropriate screening as a potential domestic abuse victim .In addition, studies[2] suggest that the 65+ age group are less likely to report domestic abuse so Francis was less likely to describe his experience using terminology that would have prompted a more appropriate response.

1.8.3. There was no suggestion that any of the nine protected characteristics was relevant in relation to the perpetrator's ability to access support services.

1.8.4 None of the family had identified any unmet care and support needs which would have required the involvement of Adult Social Care in safeguarding decisions as required by the Care Act.

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[2] Safe Later Lives: Older people and Domestic Abuse SAFE LIVES. & Standing Together Review of DHRs (2016)

1.9 Dissemination

1.9.1 The DHR will be shared with all local contributing agencies before submission to the Home Office. CCGs and NHS Trusts that are outside Walsall will be offered sight of the Executive Summary where learning points relate to their local provision.

2 The Terms of Reference for the Review

2.1 The Individual Management Review (IMR) authors were requested to consider their agency's involvement with any of the parties subject to the review from 1 January 2018, but asked to include in their chronology and consider any events or information prior to these dates if they were considered relevant to the questions framed in the terms of reference and any additional agency-specific questions.

2.2 The purpose of this review as reflected in the terms of reference is to establish:

2.2.1 If practitioners were sensitive to the needs of the victim and the perpetrator, knowledgeable about potential indicators of domestic violence and abuse and aware of what to do if they had concerns about a victim or perpetrator. Was it reasonable to expect them, given their level of training and knowledge, to fulfil these expectations?

2.2.2 If the agency has policies and procedures for Domestic Abuse, Stalking and Harassment (DASH) risk assessment and risk management for domestic violence and abuse victims or perpetrators and if those assessments were correctly used in the case of this victim/perpetrator.

2.2.3 If the agency has policies and procedures in place for dealing with concerns about domestic violence and abuse. Were these assessment tools, procedures and policies professionally accepted as being effective? Was the victim subject to a MARAC or other multi-agency fora?

2.2.4 When, and in what way, the victim's wishes and feelings were ascertained and considered. Is it reasonable to assume that the wishes of the victim should have been known? Was the victim informed of options/choices to make

informed decisions? Were they signposted to other agencies? How accessible were the services for the victim and perpetrator?

2.2.5 If the victim had disclosed to any practitioners or professionals and, if so, whether the response was appropriate.

2.2.6 Whether, in relation to the victim and perpetrator, an improvement in any of the following might have led to a different outcome:

i. Communication between services
ii. Information sharing between services with regard to domestic violence

2.2.7 Whether the work undertaken by services in this case was consistent with each organisation's:

i. Professional standards
ii. Domestic violence policy, procedures and protocols
iii. Safeguarding adults policy, procedures and protocols

2.2.8 The response of the relevant agencies to any referrals relating to the victim and perpetrator concerning domestic violence, mental health or other significant harm. In particular, the following areas will be explored:

i. Identification of the key opportunities for assessment, decision-making and effective intervention from the point of any first contact onwards. Whether any actions taken were in accordance with assessments and decisions made and whether those interventions were timely and effective
ii. Whether appropriate services were offered/provided and/or relevant enquiries made in the light of any assessments made
iii. The quality of the risk assessments undertaken by each agency in respect of the victim and perpetrator.

2.2.9 Whether practices by all agencies were sensitive to the gender, age, disability, ethnic, cultural, linguistic and religious identity of the respective family members.

2.2.10 Whether issues were escalated to senior management or other organisations and professionals, if appropriate, and in a timely manner.

2.2.11 Whether there are ways of working effectively that could be passed on to other organisations or individuals.

2.2.12 Whether there are lessons to be learned from this case relating to the way in which this agency works to safeguard victims and promote their welfare, or the way it identifies, assesses and manages the risks posed by perpetrators.

2.2.13 Areas where practice can be improved. Are there implications for ways of working, training, management and supervision, working in partnership with other agencies and resources?

2.2.14 Whether the impact of organisational change over the period covered by the review had been communicated well enough between partners and whether that impacted in any way on partnership agencies' ability to respond effectively.

2.2.15 There is some evidence (Standing Together against Domestic Violence: Adult Family Violence Briefing Sheet) to suggest that professionals, victims and families do not yet view intra-familial domestic abuse (DA) in the same way as domestic abuse involving intimate partners.

i. In your answers to the generic questions above relating to domestic abuse risk, assessment and responses, do you consider whether there is any evidence to suggest that professionals treated domestic abuse, or the risk from it in this case, differently because it involved intra-familial rather than intimate partners?

ii. What has your agency done, or what could it do, to raise awareness of intra-familial domestic abuse amongst your own professionals, victims, their families and the wider community?

2.2.16 According to the initial scoping for this DHR, the developmental disorder **Attention Deficit Hyperactivity Disorder** (ADHD) had been diagnosed in the perpetrator 'during childhood'. There are studies[3] [4] that suggest that, in some

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[3] Brian T Wymbs , Anne E Dawson , Julie A Suhr , Nora Bunford , Christine A Gidycz J Interpers Violence. 2017 Mar;32(5):659-681. doi: 10.1177/0886260515586371. Epub 2016 Jul 10. PMID: 26025345

[4] Nannet JL Buitelaar, Jocelyne A Posthumus , Agnes Scholing,Jan K Buitelaar *BMC Psychiatry* volume 14, Article number: 336 (2014)

(but by no means all) individuals with ADHD, this can lead to relationships that are more likely to involve some forms of domestic abuse. In some individuals this developmental disorder will manifest in impulsive or aggressive behaviours. They may show signs of a lack of self-control and impulsivity. This could then lead to risk within personal relationships.

a. In your agency's dealings with the perpetrator or his family, is there any evidence that any of these traits were identified in the perpetrator's behaviour?
b. Did responses demonstrate an awareness of ADHD and was the support offered appropriate?
c. Was safeguarding of individuals in the family considered?
d. What has your agency done (or what could it do) to raise awareness amongst your own professionals, families and the wider community of ADHD and of the potential safeguarding risks where an individual with ADHD suffers with aggression, and a lack of self-control or impulsivity?
e. How could this be achieved supportively, without stigmatising or victimising those individuals with ADHD?

Agency-Specific Questions

The following agencies should in addition address these questions:

- Walsall Clinical Commissioning Group
- Walsall Healthcare NHS Trust
- Dudley & Walsall Mental Health Trust

2.2.17 There is evidence from the initial scoping that in this case there was co-morbidity of ADHD, deliberate self-harm (DSH), depression and substance misuse.

a. Did your agency's involvement with the perpetrator suggest an awareness of these common co-morbidities? Did professionals assess these conditions holistically and respond appropriately?

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b. Were there responses that could/should have been offered to support the perpetrator or his family?

c. What has your agency done (or what could it do) to raise awareness amongst your professionals of appropriate support for individuals where ADHD is leading to self- harm, depression or substance misuse?

3 Background and Information

3.1 Francis and Hazel had met in 1982. They were married in 1992, and Jesse was born in 1994 and Arno three years later. Francis was employed as a traffic engineer with two different local authorities before retiring. He had played rugby and football and in later years took up golf. He was described by Hazel as '*lovely*' but she acknowledged that alcohol changed his personality and behaviours. The GP surgery Practice Manager, in a conversation with the CCG IMR author, also said he could be '*charming*' although they also encountered a change in personality caused by stress and alcohol. The impact of Francis's apparent misuse of alcohol and possible undiagnosed ADHD will be considered in the analysis.

3.2 On an evening in late August 2019, the victim Francis, his wife Hazel and their son Jesse (perpetrator) were at the family home. Both Jesse and Francis had been drinking and a dispute arose when Jesse helped himself to a can of beer in the fridge which his father said was his. The row escalated when Francis poured the contents of the can down the drain. The two men started to 'push and shove' each other and then Jesse hit his father, causing himself to fall backwards. He apparently got up again but tripped and fell a second time and fell unconscious.

3.3 An ambulance was called, and Francis was conveyed to hospital. He did not regain consciousness and died from the head injury four days later. A post-mortem determined the cause of death to be sub-arachnoid haemorrhage.

3.4 Jesse was arrested and charged with manslaughter and committed to the Crown Court for trial. He was placed on bail. The trial was due in 2020 but had not commenced. On the first anniversary of his father's death, in late August 2020, Jesse took his own life by hanging.

4 Chronology

4.1 Introduction to the chronology

4.1.1 **Author's note**: The DHR recognised that the victim had very little engagement with services and mostly routine care from the family GP. He did however reveal to the GPs, on several occasions, stress caused by various family situations offering opportunities to explore those specific concerns about his son, Jesse. In particular Francis was anxious that Jesse was not taking his medication.

4.1.2 The circumstances of the tragic death and the unpremeditated nature of the incident led Hazel to state she did not believe her husband would have wanted Jesse to face criminal proceedings. (The Chair discussed with Hazel the important public interest element of the CPS charging decision.)

4.1.3 Hazel was clear that Jesse's childhood experiences at home and at school, and the subsequent problems he experienced in adolescence and into adult life, related in large part to his attention deficit/hyperactivity disorder (ADHD) and the challenges first of getting appropriate child and adolescent ADHD support. Thereafter, as an adult, it appeared Jesse was unwilling to engage and did not want to confront the impacts of ADHD. For this reason, the chronology and analysis will be dominated by key events in Jesse's life and an attempt to illustrate the opportunities agencies had to respond to Jesse's complex needs at each stage of his life, thereby potentially reducing the harmful impact upon the whole family.

4.2 The chronology

4.2.1 According to his mother, Jesse displayed some behavioural issues as early as pre-school and primary school, but these were either dismissed by the school or not acted upon. It was not until he was 13, (2007) and at High School, that he was diagnosed with ADHD by a community paediatrician. The paediatrician felt he would benefit from medication. He was to be prescribed with Ritalin[5]

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[5] Ritalin (methylphenidate) is a nervous system stimulant that's commonly used to treat ADHD in adults and children.

from this point until his death, in 2020. (He was also prescribed other ADHD medication at various times.)

4.2.2 In 2008, Jesse was referred to Child and Adolescent Mental Health Services (CAMHS) in relation to 'anger issues', but Hazel apparently informed CAMHS that Jesse was already receiving counselling support. Jesse was re-referred to CAMHS relating to behavioural issues in 2010 and was seen six times before being discharged from the service in 2012. (The DHR has been unable to obtain details of Jesse's diagnosis and treatment plan from this period.) He had, however, been reviewed regularly by the community paediatrician until this discharge, after which it appears Jesse received no further mental health support relating to ADHD for a number of years. (This was due to a combination of a failure of ADHD services to accept a referral in 2013, Jesse's move in September 2013 to university, where he did not engage with support offered, and later by Jesse's reluctance to undertake pre-appointment requisite blood tests.)

4.2.3 At this time, both nationally and locally, there was a widespread absence of commissioned services and pathways from CAMHS into adult support for ADHD. This will be developed in the analysis.

4.2.4 There were no episodes of note for Francis or Jesse in the intervening period, but in September 2013, at 19, Jesse started a degree in English at Lincoln University. (He graduated from this course in May 2016 at which point in September 2016 he started an MA in creative writing, dropping out from the course in May 2017.)

4.2.5 He registered with the University of Lincoln Health Service (ULHS) in October. ULHS could not transfer his Walsall GPs electronic records and paper records took five months to arrive. In January 2014 Jesse explained to ULHS that he experienced ADHD and sought continuation of his Ritalin prescription. ULHS received confirmation of this from the Walsall GP within 24 hours.

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4.2.6 In December 2013, Jesse had been treated in Birmingham for an assault causing a fractured jaw which was followed up with surgery in Lincoln hospital. Over the years in Lincoln, a pattern emerged of presentations (eight in total) at Lincoln hospital for a combination of inflicted and accidental injuries.

4.2.7 In February 2014 Jesse contacted an out-of-hours service in Lincoln to obtain a repeat Ritalin prescription having apparently lost one on the way to the pharmacy. He was given a new prescription for a month's supply. (Over the following years, Jesse claimed to have lost prescriptions on several occasions.) He also sought repeat prescriptions through both GPs and out-of-hours service.

4.2.8 In July 2014, Jesse presented at Lincoln Accident & Emergency (A&E) with abrasions to the scalp having apparently intervened in a pub fight and been hit on the head with a bottle. In April 2015, he again presented at A&E with a 'deep' laceration to his right wrist having apparently cut his wrist on a bottle. He was with his then girlfriend. Although his explanation was not challenged, it is very possible this was a first example of presenting at A&E with DSH injuries. In November, he presented with contusions to the upper arm which were consistent with a 'sporting injury'.

4.2.9 Francis mentioned his '*worries'* about Jesse to his GP during reviews in October 2015. The GP notes for the Walsall practice were cursory and therefore the CCG IMR author was unable to provide any background to this conversation.

a. Learning point: All GPs should ensure that patient records comply with the GMC Guidance[6] with regard to the quality and detail required. (The Walsall CCG will address this concern with the practice.)

4.2.10 The university's Student Wellbeing Service was approached by Jesse seeking counselling for anger management in late December 2015. The next term, January 2016, the SWS and the counselling providers made repeated attempts to engage with Jesse who eventually responded in March that he was 'fine'. At

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1. [6] GMC Good Medical Practice (2013) and Medical Defence Union MDU Good record keeping

this time, at home in Walsall, Francis again discussed his concerns for Jesse's mental health with his GP (Jan 2016).

4.2.11 In 2016, ULHS made attempts to address adult ADHD with Jesse, with limited levels of engagement. He did not attend a medication review in May. He was referred to a unit dealing with adult mental health and neuro-psychological services as well as a specialist psychiatrist in June but did not attend. In July, ULHS records provide a rare glimpse of an awareness of the problematic relationship Jesse felt he had with his parents. They include one line '*tough situation with family at the moment*.'

4.2.12 Albeit the medical records available to the DHR were scant, there is a hint of ongoing issues when in early October 2016 the patient record for Jesse records '*MH worker in A&E saw patient weekend*.' The lack of detail unfortunately means this could have been at any A&E; it was not recorded in Lincoln Hospital records.

4.2.13 At around this time Jesse's personal life was causing him anxiety. Jesse had been with the same girlfriend since the second year of university, (2014) but the relationship ended at Christmas 2016. Hazel, Jesse's mother, said in conversation with the Chair that she had been '*very good*' for Jesse; encouraging him to work and stay focussed. The break-up led, according to Hazel, to his ex-girlfriend posting '*bad things*' about him on Facebook that led to problems with their mutual friends, and this may possibly have contributed to his mental health deterioration.

4.2.14 In January 2017, Jesse called the out-of-hours service having panic attacks and requesting medication; when this was refused, he was '*abusive, shouting and swearing*'. (This, and all other attendances or calls to the out-of-hours service were shared with ULHS.) A ULHS patient note the same month once more recorded Jesse saying, '*parents are overpowering*'. Jesse made contact with SWS in early February and attended a drop-in to discuss relationship issues and mental health.

4.2.15 In mid-February 2017 at 22 years old, Jesse apparently attended a re-scheduled appointment with a psychiatrist. This appears to have been his first ADHD-related appointment with a professional with ADHD expertise since he was 17. The psychiatrist felt ADHD was being controlled and he did not find any co-morbid mental health disorder. ULHS stated that at this time (and it apparently remains the case) there was no specialist adult ADHD provision in Lincolnshire and therefore a specialist review of Jesse's medication was not possible. They were advised to maintain the current medication regime.

4.2.16 The next day, Jesse took an overdose of 10x 30mg of Ritalin and consumed a large amount of alcohol and was taken into A&E accompanied by Lincoln Police. He had injuries to his knuckles, having '*punched a wall*'. The cause of the incident had apparently been seeing his ex-girlfriend kiss another man. The Mental Health Liaison Team (MHLT) identified that Jesse regretted his actions and '*would not do it again*.' He denied any other drug use.

4.2.17 Jesse already had a general review appointment at ULHS booked for the next day but he did not attend. When ULHS received a discharge letter five days later, Jesse was offered a follow-up appointment, but he refused it. The ULHS did not take this incident further.

4.2.18 Although the ULHS and Walsall CCG IMRs give no real indication of Jesse's possible alcohol misuse at this time, there is evidence that it must have been discussed and considered in relation to the impact it would have on ADHD medication and his mental health. The ULHS records identify several occasions where Jesse claims to be not drinking or reducing alcohol. (In 2016 the Walsall GP had offered Jesse the contact details for 'Beacon', the alcohol and drugs service in Walsall.)

4.2.19 At the same time, Jesse was in contact with SWS. He was struggling with his MA, (his attendance on his degree and MA was low; 47%). In mid-February he attended SWS with his father, Francis, to discuss 'extenuating circumstances' that could allow him to continue on his MA. Hazel also called SWS to discuss a loan laptop because Jesse's was broken. Although his parents were supporting him, Jesse chose to attend any discussions around his relationships or mental

health and academic issues on his own. He was seen three times, but also frequently cancelled appointments.

4.2.20 The DHR understands that Jesse started a relationship with Chloe, a local woman, in spring 2017. She had a child from a previous relationship living with her. Their relationship appears to have been volatile. In October 2017, Lincolnshire Police recorded two separate calls to loud arguments in one week.

4.2.21 At the beginning of November 2017, Jesse attended A&E in Lincoln for the last time. Following an argument with Chloe, Jesse had cut his wrist with a serrated knife. He did not require further treatment and a GP follow-up was advised. Any MHLT involvement was not recorded. ULHS appeared unaware of this second self-harm episode. By this time Jesse had all but dropped out from his MA and probably was no longer considered an enrolled student.

4.2.22 Hazel was aware of an attempted self-harm incident during this period where Jesse '*threw himself in front of a car*' and was injured. The DHR could find no confirmation of this on medical records.

4.2.23 Jesse went to work in Prague, Czech Republic, as a recruitment consultant at the end of 2017. There was growing evidence during this period that Jesse's alcohol consumption was proving problematic and that it was having a serious impact upon his wellbeing.

4.2.24 Jesse and Chloe spent Christmas 2017 with his parents in Walsall. On New Year's Eve, Chloe and Jesse went to Nottingham. During the course of that evening Jesse went missing. In the early hours Chloe called the house and asked to speak to Francis. She was calling from a crisis centre to say she had suffered a sexual assault by a security guard at a club. Hazel and Francis attended but Francis dropped Hazel at the crisis centre and Francis went in search of Jesse. When found, Jesse was angry and distrustful of Chloe's account of the incident. Hazel was very scared that Jesse would hurt someone or himself and asked police not to let him in to the centre. Immediately she came out Chloe and Jesse got into a fierce verbal argument and police had to

calm the situation. On the journey home, whilst travelling at speed on the M1, Jesse threatened to jump from the car, opening the car door.

4.2.25 Once home in Walsall, Jesse threatened to cut his wrists, apparently in order to coerce an account from Chloe that he was prepared to believe. Francis tried to restrain Jesse, who had a knife and had inflicted minor superficial wounds on himself. Although Chloe was removed from the situation, staying with Hazel's sister, Jesse remained volatile, was intoxicated and police were called. He was given the opportunity to go to a friend's, but he returned whilst officers were present and requested more alcohol. He was arrested to prevent a breach of the peace and remained in custody overnight.

4.2.26 He was reviewed by Diversion and Liaison Mental Health team the next morning. It was recorded that he suffered with depression and anxiety, with a history of self-harm by cutting his arms, and was non-compliant with medication, apparently due to side effects. Jesse was described as polite and calm in mood but anxious due to the circumstances leading to his arrest. It was stated that there was no evidence of psychosis through disorder or paranoia, and he denied any ideation of self-harm or suicide. He was advised to self-refer to his GP about his medication and anxiety. There is no evidence Jesse took up this advice.

4.2.27 Jesse briefly returned to Prague but came back almost immediately because of Chloe's demands. In January 2018, Lincolnshire police attended Chloe's to a verbal argument where Jesse was refusing to leave. When Jesse returned again to Prague, he self-harmed, lacerating his hand. His employers tried to persuade him to seek mental health support in the city, but he refused and flew to Stansted and, refusing Francis's offer of a lift, took a 120-mile taxi journey to Lincoln.

4.2.28 In mid-February 2018, Lincolnshire police attended Chloe's for the last time, where, although Jesse was present, she reassured officers that they now '*lived in separate cities.'* She completed a Public Protection Notice.[7]

4.2.29 At some point whilst Jesse was in Prague a taxi driver allegedly overheard him claiming to have '*murdered his girlfriend*.' The driver and local police were sufficiently concerned to inform West Midlands Police via the National Crime Agency. In February 2018, after talking to Hazel and Francis, who said he was in Lincoln and was '*suicidal',* a 'safe and well' check was carried out by police on both Chloe and Jesse. The episode went no further. However, the impact of this incident appears to have led to a mental health crisis.

4.2.30 Jesse returned from Lincoln and was once more home and living with his parents. This placed a considerable strain on the whole family. His mental health was precarious, he was abusing alcohol, possibly using cocaine and it transpired, '*snorting'* Ritalin, his ADHD medication.

4.2.31 Francis appears to have become desperate for help and went to the GP's surgery where his anxiety led to an *'aggressive outburst'* which was witnessed by the practice manager. He was advised to call the police if he felt he could not cope with Jesse.

4.2.32 Hazel described a further DSH incident during this period. Jesse and Francis had been watching a film at night when Jesse came into Hazel's room with '*his arm split open'.* Jesse would not accept an ambulance being called and the injury was treated at home.

4.2.33 A few days later, at the end of February 2018, Jesse was feeling increasingly agitated and had thoughts of ending his life. He agreed to go with Hazel and Francis to A&E, absconded but was returned by staff. He was then directed to the MHLT. He was seen on his own with a Community Psychiatric Nurse (CPN). He expressly instructed that nothing be shared with his parents.

1.

[7] Officers who attend incidents complete a **public protection notification** document (PPN) which summarises the vulnerabilities of victims. This **notice** goes to the force **public protection** unit (PPU) which uses the information to assess the risk.

4.2.34 The mental health assessment provides the only clear summary available to the DHR of Jesse's mental health, DSH, alcohol and drugs abuse during this critical time. He presented with old DSH injuries that required stitches. He described his childhood ADHD diagnosis and the lifelong impact it had had.

4.2.35 Jesse described himself as a '*chronic alcoholic',* describing his agitation as being due to not drinking. He described consuming three litres of strong cider, four cans of beer and a bottle of wine the day before. He said anger and alcohol fuelled his DSH. The Dudley & Walsall Mental Health Trust (DWMHT) IMR recorded: 'Jesse *described his personality as impulsive and unpredictable and that he often instigated fights with males when he was out. He reported that he enjoyed fighting and often cut himself when angry and intoxicated and that some cuts had required medical intervention. Jesse stated that he had been a regular cocaine user but now only used it socially.*' The DWMHT IMR noted that Jesse was discharged back to his GP and a referral to Adult Neurodevelopment Services[8] suggested. Jesse was '*provided with information regarding addiction services*.'

4.2.36 The same CPN recorded a telephone conversation with Hazel and Francis four days later. They called trying to find out the outcome of the assessment, because Hazel recollected, Jesse told them '*nothing'*. The CPN properly informed them of the confidentiality issues and Francis asked for advice. He had opened a letter from Jesse's employer In Prague that day; his contract had been terminated for using alcohol at work.

4.2.37 Hazel had expected Jesse to be 'sectioned' after the assessment and was frustrated and asked for advice on what to do if Jesse experienced a mental health crisis. She was advised by the CPN to call police and the crisis team.

1.

[8] This service offers assessment and advice on pharmacological treatments for patients suspected of or having a diagnosis of ADHD or ASD. This is done through a shared care protocol with the patients' GP. Funding will need to be agreed by the relevant Clinical Commissioning Group before any work is undertaken, evidence of which should accompany the referral. Any co-morbid conditions are managed by the local adult psychiatric service.

The DHR noted that the CPN did not advise Hazel concerning her right as a nearest relative[9] to request that a Local Authority Approved Mental Health Practitioner (AMHP) consider a Mental Health assessment[10] of Jesse should the family feel he was in crisis. Whilst this pathway is infrequently used, it may have provided reassurance to Hazel that she could access Mental Health support for her son, without the need to call Police and CRISIS team or persuade him to self-refer through the GP. Given Jesse's reluctance to engage with services, it was unlikely he would have agreed to go to his GP and seek a mental health assessment.

b. Professionals should be aware of the right of a 'nearest relative' to request the Local Authority AMHPs consider a mental health assessment of a family member, under section 13. (4) of the Mental Health Act 1983 and agencies should ensure they provide guidance and training to their staff so that they can provide accurate, helpful advice to families on this pathway.

4.2.38 Hazel also recollected in conversation with the Chair rather more informal advice she was given by the CPN; '*do not stop Jesse drinking, as it would kill him'.* Hazel asked the CPN to speak with Jesse's GP, which they did.

4.2.39 The practice manager told the CPN about the incident with Francis a week earlier (paragraph 4.2.30 above), when Francis had told her that Jesse was allegedly using 'narcotics', breaking open Ritalin capsules and allegedly snorting them. The CPN requested that the GP refer Jesse to the community

1. _____

[9] Section 26 of the Mental Health Act explains who a nearest relative. (NR). A person cannot choose their NR. The general rule is that your NR will be the person who comes highest on the list, but there are other rules that may affect who your NR will be.

1. Husband, wife or civil partner
2. Son or daughter
3. Father or mother
4. Brother or sister
5. Grandparent
6. Grandchild
7. Uncle or aunt
8. Niece or nephew

[10] Guidance on the scope and application of section 13(4) MHA 1983
https://www.rethink.org/advice-and-information/rights-restrictions/mental-health-laws/nearest-relative/

mental health team. The GP referred Jesse to the Adult Neurodevelopment Team, which required that blood tests were submitted before attendance. Through April 2018, the surgery made several attempts to contact Jesse to arrange these tests, but with met with no response. It therefore took 16 months before Jesse was seen at this specialist neuro-developmental team which is now called the Adult ADHD and Autism Service (AAAS).

4.2.40 In relation to the abuse of medication, that the surgery had apparently become aware of the previous week, there is little evidence of any reaction other than a one-line entry in Jesse's notes, recorded the same day the CPN called, which appears to be a complaint by Jesse that '*short duration prescriptions are costing more money*'. There is therefore little indication of any multi-disciplinary reaction after the conversation between the CPN and practice manager.

4.2.41 In the first week of March 2018, Francis spoke at length again to the GP about Jesse. Two lines in his notes indicate his position; '*he was scared of his son as he is a lot bigger than he was. Support offered but he did not want to accept it as it was his son*.' At the consultation Francis's alcohol consumption was addressed and records make it clear his increasing alcohol misuse was being noted in 2018.

Recommendation: The Black Country and West Birmingham CCG should ensure that practitioners are confident to identify the signs and risk of intra-familial domestic abuse and that referral pathways are identified when a victim is a parent, and the offender is an adult.

4.2.42 The relationship between Chloe and Jesse had deteriorated so significantly that in April 2018, Jesse reported to West Midlands Police that she had 'hacked' his email and changed his name to 'woman beating … cheating pig.' (The name-calling included other extremely abusive language.) Ultimately, Jesse never made a substantiated allegation, and the matter was not investigated further.

4.2.43 In late April 2018, Jesse advises the Walsall GP surgery he was moving. In May 2018, Jesse moved for a period to Cornwall, working in hospitality. This meant any attempt to get ADHD support in Walsall was on hold. The Walsall GP wrote

to the new surgery in Cornwall. (He was registered with a local GP from May until October.) The Cornish surgery did not have any electronic transfer of note or files and therefore were reacting simply to Jesse's disclosures. They would have been unaware of the abuse of medication and other concerns in February. He declined local counselling services and no adult ADHD services were available locally.

4.2.44 Jesse's medical records for the period from May to October include in June 2018 the Cornwall GP stating that they were '*not happy to prescribe longer until he is seen by a psychiatrist'.* It is unclear whether this relates to any prescribing, or the quantity of medication supplied. They had already challenged a claim by Jesse that he had lost prescriptions and GP notes describe Jesse as '*ranting and raving*' when a GP refused to replace a lost prescription. It may have been that these appropriate challenges to the level of medication and lost prescriptions precipitated his move back to Walsall. Jesse re-registered with his Walsall GP in October 2018.

4.2.45 When Jesse returned to Walsall he moved in again with his parents. Hazel described Jesse as becoming increasingly withdrawn and reclusive living like a '*hermit'*. He would pile blankets behind the door, making it impossible to push open. Jesse's room was '*terrible and his personal hygiene got worse*.' He seldom left the room and took to urinating into bottles. He slept very poorly, and the medication impacted upon his appetite.

4.2.46 In November 2018, the Walsall GPs re-referred Jesse to the AAAS and funding for support was agreed by the CCG in April 2019. Jesse had been assessed in June by the surgery using mental health anxiety and depression monitoring tools, GAD7[11] and PHQ9[12], that showed his anxiety and depression to be

1.

[11] **Generalised Anxiety Disorder** Assessment (**GAD**-**7**) This easy-to-use self-administered patient questionnaire is used as a screening tool and severity measure for **generalised anxiety disorder** (**GAD**)

[12] The **PHQ**-**9** is the depression module, which scores each of the nine DSM-IV criteria as "0" (not at all) to "3" (nearly every day). It has been validated for use in primary care. It is not a screening tool for depression but it is used to monitor the severity of depression and response to treatment.

between moderate and severe which would indicate a need for psychiatric assessment.

4.2.47 In June 2019, Jesse attended his initial appointment with the team. His immediate appearance and presentation were commented on favourably. It seems likely that Hazel had, understandably, encouraged Jesse to 'smarten himself up'. However, this probably masked his level of self-neglect which was not helpful to an understanding of Jesse's present situation.

4.2.48 It is noteworthy that usual practice is that patients are advised to attend with someone (normally a family member) who can help describe and contextualise the patient's lived experience. Jesse chose to attend alone. He described conflict with his family and blamed Francis's alcohol consumption for the problems. He stated his belief that his father, Francis, had undiagnosed ADHD. He described his history covering his time in Lincoln and Cornwall.

4.2.49 As Jesse had a previous NHS diagnosis of ADHD, he was offered a symptom impact assessment and a review of his medication. He stated that he was actually happy with his current prescribed medication but as his GP was new to the practice, they had requested a referral to the AAAS.

4.2.50 Jesse's second appointment was on the 6th August 2019. He was seen by the specialist AAAS nurse. The service required that the service user was accompanied to this appointment by either a parent or carer, partner, colleague or sibling – Jesse once again attended alone.

4.2.51 He stated that that his sleep was inadequate although he thought medication did not adversely affect it. There was apparently no evidence of any mood disorder and engagement was good and therefore no formal assessment of cognition was made. The nurse noted self-care appeared to be good. Jesse displayed good eye contact '*and a rapport was readily established*'. He apparently expressed his thoughts and feelings well and answered questions put directly to him. His speech was observed to be fast in rate but normal in tone and quantity. There was no evidence of any sustained low mood or suicidal ideation. Though no formal assessment of risk was completed, risk to

self and others appeared low. Jesse was described as appearing optimistic about his future and had a good insight into his condition and was happy to commence medication to manage his ADHD symptoms.

4.2.52 A further review was offered in 10 weeks' time, and he was encouraged to contact the service should he require support before his next review. The GP was informed of the outcome by letter.

4.2.53 This was the last contact Jesse had with professionals before the incident leading to Francis's death some days later.

5 Analysis

5.1 Introduction to the analysis

5.1.1 The family in this DHR suffered a double tragedy, the homicide of Francis and the subsequent suicide of Jesse. Although the incident itself appeared to be a combination of the mundane and the predictable, another petty row between father and son, leading to a careless single blow with unimaginable consequences, the risk of such an incident was ever present in a father and son relationship that was characterised by a lack of mutual understanding and ever growing tensions.

5.1.2 Over many years, it seems the signs of family stress were often visible, and the deteriorating relationships increasingly apparent. The DHR will analyse whether it was reasonable to expect professionals to recognise these 'fault-lines'. In the light of known circumstances, what support or safeguarding responses, could reasonably be expected?

5.1.3 Central to these considerations are the proper transitions in care from childhood to adulthood. Whilst in relation to a child, needs can be identified and support should be offered to a child and family, services need to be aware of any gap in provision when a child becomes an adult. Adults may exhibit increasing vulnerability, but their acceptance of support is entirely in their hands. Identifying what help and services they will accept and why they may refuse support, needs a proper understanding of risk, particularly where there

are specific co-morbidities that are known to often lead to poor outcomes. Adult safeguarding in its broadest sense requires professionals to be alert to these risks and share their concerns with that adult and where appropriate with other professionals.

5.1.4 This DHR acknowledges that the primary responses to the needs of Jesse and the rest of the family were focused on a childhood diagnosis of ADHD which, during the period under consideration, would have been the 'default position' in response to childhood presentations like Jess's. With hindsight, it is apparent that Jesse and his sibling were loved and nurtured by their mother, but she had to content not only with Jesse's vulnerabilities, but also the unmet needs of her husband, Francis, which led to his comprised parenting style.

5.1.5 These undisclosed or concealed elements of the family dynamic, had they been identified, could have provided a more nuanced understanding of Francis's parenting and Jesse's presenting behaviours. They could have led to a properly informed assessment of the needs of the whole family. This would have required, in the context of child ADHD, an understanding of the potential causes of Jesse's lack of emotional self-regulation.

5.1.6 Key to this level of understanding, was an awareness of the father's possible undiagnosed ADHD, his frequent alcohol misuse and his consequent apparent inability to provide authoritative, rather than authoritarian parenting to Jesse. Jesse needed love and warmth from his father, together with appropriate boundaries and rules and fair discipline. Instead, he experienced ridicule, bullying and inappropriate punishments and boundaries with the evident impact on his emotional wellbeing that he carried into adult life.

5.1.7 It seems that Francis was unable to provide 'good enough' parenting, probably because his own need for mental health support had gone unrecognised for so long. It is quite possible that his alcohol misuse was a consequence of these unmet needs. Francis was arguably vulnerable to a breakdown in his personal relationships, because of a lack of self-awareness regarding his own unresolved issues.

5.1.8 The description of Jesse's childhood, drawn from his mother's personal experiences and Jesse's girlfriend's conversations with him, suggest that Jesse and his sibling grew up with a father who was coercive and controlling of the whole family and whose use of alcohol increased the frequency and risk of domestic abuse.

5.1.9 With hindsight, Hazel recognised she and the family were victims of domestic abuse at the hands of Francis. For years she had 'excused' him because she saw alcohol as the cause, and latterly her growing awareness of her son's ADHD led her to recognise that her husband may have been living with undiagnosed ADHD in adulthood. The impact of alcohol upon Francis was to apparently make him angrier and more confrontational with both Hazel and Jesse. Experiencing and witnessing domestic abuse and living with a parent with problematic drinking or mental ill-health are all recognised as Adverse Childhood Experiences (ACEs).

5.1.10 Dr Nadine Burke Harris in her book 'Toxic Childhood Stress', emphasises that a child experiencing the adverse biological changes she calls toxic childhood stress, is likely to have experienced four or more ACEs over a prolonged period. It is therefore a sustainable argument that Jesse's apparent ADHD could be argued to have been a misdiagnosis, where a recognition of toxic childhood stress may have been more helpful. Even if the full biological impacts of ACEs cannot be identified retrospectively, the psychological impact of ACEs which seem self-evident, could account for Jesse's growing hostility toward his father.

5.1.11 As Jesse grew up, behavioural issues that had been identified in primary and secondary school were also being mirrored in his increasingly violent responses to his father. As his physical strength increased, his ability and willingness to challenge his father's bullying, changed the family dynamic. If this change in the family dynamic had been shared with professionals, it would probably have been seen entirely in the context of Jesse's diagnosed ADHD, rather than a response to Jesse's experience of ACEs and compromised parenting. The understanding of Child and Adolescent to Parent Violence and Abuse (CAPVA) has changed dramatically since the period under review.

5.1.12 Helen Bonnick, in her work Child to Parent Violence and Abuse: A Practitioner's Guide to Working with Families recognises the challenge where 'shame and blame' are so often attached to either a child's violent or abusive behaviours or an adult's inappropriate or ineffective parenting style. The family relationships in this case were compromised because of the range and extent of unresolved issues that needed a systematic and comprehensive family assessment. This DHR has focused on the apparent lack of effective support Jesse and his mother received with his ADHD, but in 2022, it is to be hoped that both ADHD support but also an awareness of ACEs and CAPVA, would influence assessments.

5.1.13 The DHR will consider the apparent inadequacy of the support offered Jesse and his family to understand and address the challenge of ADHD throughout his life. As a child Jesse was diagnosed with ADHD but largely let down by the quality and level of support offered. The absence of a proper transition to adult services left him vulnerable. His time at university, apparently culminating in a degree in English, would tempt professionals to consider that in relation to his ADHD, he was 'high functioning'. In reality this judgement fails to recognise the realities of his period spent at university. His last girlfriend, Anika, told the Chair that Jesse felt he '*went off the leash'* at university. Anika said that in her experience, Jesse was impulsive and lacked any self-control in relation to alcohol, the use of medication and substances, or in relation to the ability to walk away from conflicts both verbal and physical. Impulsivity and lack of self-control are key issues in understanding why there is an elevated risk of substance misuse linked to adult ADHD. Studies have shown that where ADHD manifests in anger, aggression or conduct disorder[13] there is an increased risk of substance misuse, DSH and poor mental health.

5.1.14 The chronology described the very real detrimental impact ADHD had upon Jesse, his family, friends and colleagues, in childhood and adolescence into

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[13] Milberger S, Biederman J, Faraone SV, et al (1997) Associations between ADHD and psychoactive substance use disorders. Findings from a longitudinal study of high-risk siblings of ADHD children. American Journal on Addictions 6: 318–29. Molina BS, Pelham Jr WE (2003) Childhood predictors of adolescent substance use in a longitudinal study of children with ADHD. Journal of Abnormal Psychology 112: 497–507.

adulthood. It also reveals the very real risks where there is co-morbidity of ADHD, DSH), mental health concerns and substance misuse. The actual impact upon Jesse's life were not hidden; they were evident in his hospital presentations after fights, and DSH episodes and were detailed in assessments with MHLT and the AAAS. However, because primary care medical records are not viewable in secondary care, Jesse's full medical history would not have been available to A&E. His possible misuse of his medication was identifiable, provided that a professional viewed his recorded history. The DHR will identify the need for greater awareness of adult ADHD, particularly where there are these co-morbidities.

5.1.15 CCGs and NHS England are only now establishing pathways between childhood and any adult ADHD services, which remain far from widespread and universally available. The DHR will address current service provision in Walsall and identify whether a child presenting with Jesse's needs would be better served today. The DHR shared its findings with Lincolnshire and Kernow (Cornwall) CCGs to support better provision in those regions.

5.2 Childhood ADHD and transition into adult support for ADHD

5.2.1 The Panel were aware that Jesse and his family's experience of support in relation to childhood and adolescent ADHD reveals attitudes and service provision in Walsall in the early to mid-2000s. It is often not particularly helpful to analyse the weakness in service provision or awareness at a given time, when it may not reflect the current position.

5.2.2 The panel did consider that the DHR provided an opportunity to review current service provision in Walsall in relation to Children, Young People and Adult ADHD support. It was the view of those on the panel, that there may remain gaps in ADHD awareness amongst professionals. Families in Walsall may still struggle to obtain appropriate services for children and young people with ADHD and transition from CAMHS to AAAS may be problematic due to funding issues and capacity.

5.2.3 The panel felt that the SWP should seek assurances from CCG commissioners that a child, young person or adult presenting for diagnosis and support could get speedy access to appropriate services for both them but also their families. In this regard, the Chair felt national and international ADHD charities such as the Attention Deficit Disorder Association (ADDA)[14] now provide websites offering the kind of holistic advice and support that could empower children and families, which was probably not the case in the early 2000s.

c. Learning point: Public Health, Black Country CCG and Children's Services Access & Inclusion Team in Walsall should ensure that GPs and education providers are aware of self-help resources that empower children, young people and families experiencing ADHD

5.2.4 However, understanding how Jesse's mental health and his control and understanding of ADHD were impacted by childhood experiences, is crucial to understanding the surrounding circumstances behind this homicide.

5.2.5 The impact of adverse childhood experiences can be lifelong and a child's enduring sense of shame relating to their ADHD starts if they feel blamed for their behaviours, rather than helped to understand the biological and genetic causes and given support. A child with ADHD can learn coping strategies and their family can adapt their diet and promote healthy activities, understand better communication, discipline and boundaries with their child. If, however, blame, anger and aggression and harsh responses are experienced by the child at home, it will be hard to reverse the negative impacts of ADHD.

5.2.6 The DHR Chair's conversation with Hazel revealed how Jesse's ADHD came to light and the struggle she experienced getting support. Very significantly, she received no support from Francis in relation to Jesse's needs, because he was in '*absolute denial*'. The Chair noted that both Hazel and Jesse felt fairly certain that Francis himself had undiagnosed ADHD in adult life. Hazel said that her husband and Jesse reacted and behaved in identical ways. Francis was '*socially*

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[14] https://add.org/ Attention Deficit Disorder Association website provides learning resources and promotes wellbeing and awareness

awkward' until he had a drink. There is no longer any serious debate concerning whether ADHD is inherited and genetically linked. Numerous studies have shown how often ADHD is present in one or both parents of children with ADHD[15].

5.2.7 Jesse's behaviours at pre-school and nursery caused Hazel concern; he was defiant and argumentative and non-compliant. At home his sleep patterns became disturbed. The nursery staff felt it was too early to get Jesse assessed but at primary school his behaviour continued to be disruptive and aggressive. With the exception of Year 2, where a form teacher understood his needs and provided an oasis of calm, Jesse became increasingly angry at primary school. He told professionals later in life he had been bullied and had become a bully himself.

5.2.8 Hazel acknowledged that at home the family dynamic was not conducive to providing stability for Jesse. Francis was argumentative when drunk and this was an increasingly common experience when the children grew up. It led to frequent confrontations witnessed by the children. Hazel felt Francis was overbearing and controlling of her and the boys, but not generally physically abusive, although she remembered an occasion when after Jesse swore at a primary school teacher, Francis smacked him with a slipper. 'Bad behaviour' was often punished by Jesse being sent to bed without food.

5.2.9 Hazel recounted many incidents of confrontation between Francis and Jesse. The frequency and intensity of the confrontations increased as Jesse grew up. She felt Francis's punishments were often misguided and inappropriate. He removed light bulbs from Jesse's room because he was scared of the dark as a child. When Jesse asked to be given privacy, Francis removed the bedroom door. He would remove cables from Jesse's PlayStation. On another occasion, when Jesse did not immediately respond to his father, because he was watching a film, Francis cut the household's internet cable.

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[15] Thapar A, Langley K, Owen MJ, O'Donovan MC. Advances in genetic findings on attention deficit hyperactivity disorder. Psychol Med. 2007a Dec; 37(12):1681–92. E pub 2007 May 17.

5.2.10 Anika, Jesse's last girlfriend, said Jesse spoke about his father's treatment of him '*all the time'* and said alcohol played a '*massive part'*. She gave examples recalling what Jesse had told her: Francis 'accidentally' burnt Jesse with a hot light bulb when changing it.

5.2.11 Hazel was entirely on her own in trying to get recognition of Jesse's condition. Francis refused to address ADHD and believed that his disciplinary measures would control Jesse's 'bad behaviour'. Hazel was referred for help to a consultant paediatrician who wrote to Jesse's primary school. Hazel said the letter was ignored. Feeling let down by the response of the primary school, Hazel ensured that Jesse's secondary school was out of area so the adverse responses would not follow Jesse.

5.2.12 When the secondary school encouraged an ADHD assessment and it was finally diagnosed at 13, he was prescribed Ritalin. Francis was furious, saying his son would be '*labelled*'. Tension between Jesse and his father increased with Hazel increasingly cast in the role of peacekeeper.

5.2.13 There appeared to be a missed opportunity in this case to provide the family with support and education that may have informed Francis's understanding of his son (and probably his condition). This would not be without its challenges. If Francis had ADHD that would mean that the presence of adult ADHD on parenting programmes for parents of children with ADHD could lead to a '*cycle of difficulties'*[16]. However, the absence of family work in this case was a serious omission.

5.2.14 NICE guidance[17] published in 2008, (revised in 2018) had identified the standard required of services commissioned by CCGs; '*If the child or young person's behavioural and/or attention problems suggestive of ADHD are having an adverse impact on their development or family life, consider: a period of watchful waiting of up to 10 weeks and offering parents or carers a referral to*

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[16] V.A.Harpin The effect of ADHD on the life of an individual, their family, and community from preschool to adult life

[17] Section 1.2.7 Attention deficit hyperactivity disorder: diagnosis and management NICE guideline Published: 14 March 2018 www.nice.org.uk/guidance/ng87

group-based ADHD-focused support (this should not wait for a formal diagnosis of ADHD)'.

5.2.15 The critical need to work and educate families where a child is diagnosed with ADHD was recognised in 2018 revisions to the NICE guidance. The approaches advocated would surely have helped in this case.

- *Ask families or carers of people with ADHD how the ADHD affects themselves and other family members and discuss any concerns they have. Encourage family members or carers of people with ADHD to seek an assessment of their personal, social and mental health needs, and to join self-help and support groups if appropriate.*
- *Offer advice to parents and carers of children and young people with ADHD about the importance of positive parent– and carer–child contact, clear and appropriate rules about behaviour and consistent management structure in the child or young person's day.*

d. Learning point: Professionals working with families where children are diagnosed with ADHD should be aware of the need to work with the whole family and identify their strengths as well as areas that require attention and support. A 'whole family' approach will always be helpful.

Recommendation: The Black Country & Birmingham West CCG and The Black Country Healthcare Foundation Trust should ensure that current provisions of child ADHD services are age appropriate and should audit to identify the extent to which services meet the NICE Guidance in relation to identifying the impact of ADHD upon the whole family. These agencies should be able to describe how a 'Whole Family' approach can be evidenced in ADHD services.

5.2.16 Although the paediatrician reviewed Jesse regularly until 2012, it does not seem that the interventions offered were helpful. When at thirteen, Hazel sought help relating to Jesse's consistent anger management problems, he was sent to an entirely inappropriate session with 5–6-year-olds. In conversation with the Chair, Hazel made no mention of any support offered by CAMHS; it seems the six sessions Jesse attended had very little positive impact. The DHR

was unable to obtain details of the areas addressed and any recorded views about Jesse's ADHD. It does not appear there was any clear diagnosis in letters to the GPs.

e. Learning point: Services offered to children and young people with ADHD must be age appropriate and take into account the different needs of children and adolescents.

5.2.17 It is possible that Jesse's ADHD was accompanied by Antisocial Behaviour or Conduct Disorder that could account for his aggression and anger. The NICE[18] guidance in this regard states '*conduct disorders commonly coexist with other mental health problems: 46% of boys and 36% of girls have at least 1 coexisting mental health problem. The coexistence of conduct disorders with attention deficit hyperactivity disorder (ADHD) is particularly prevalent and in some groups more than 40% of children and young people with a diagnosis of conduct disorder also have a diagnosis of ADHD'.*

5.2.18 It seems to the DHR though, that Jesse's early experience of parental substance misuse and domestic abuse were very likely to have influenced his behaviours in a negative way. Whilst anger and aggression can be a symptom of ADHD, it is hard to be sure whether it was a reaction to a father's shaming of a vulnerable child.

5.2.19 As the boys grew up, Jesse became physically more able to confront Francis. By 15-16 he was a physical match with his father. On many occasions in adolescence, Francis and Jesse were involved in physical pushing and shoving and were '*at each other's throats*'. The boys became aware as teenagers of a serious breach of trust between Francis and Hazel and she felt their respect for their father, already compromised by his use of alcohol, was further diminished. The likelihood that Jesse would confront Francis increased also; Hazel said he was '*protective toward her'.*

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[18] NICE: Antisocial behaviour and conduct disorders in children and young people: recognition and management Clinical guideline Published: 27 March 2013 www.nice.org.uk/guidance/cg158

5.2.20 Discharged from CAMHS in October 2012 at 17, Jesse still received Ritalin and the prescription was reviewed and repeated by the GP, but not managed by an ADHD specialist thereafter. There is absolutely no suggestion that Jesse was no longer affected by ADHD. It was entirely predictable that he would continue to suffer the condition into early adulthood.

5.2.21 It would appear that Jesse's GP did attempt, in July 2013, (following a request from the community paediatrician), to refer him to adult ADHD services. The referral was not accepted because CAMHS had not diagnosed ADHD. This seems a missed opportunity to assure continuity of care and given the well recorded concerns surrounding ADHD, as well as prolonged use of medication for such a condition, appears a puzzling decision.

5.2.22 A study in 2015[19] identified the related risks: '*There is increasing evidence that problems related to childhood ADHD can persist into early adulthood and that they can act as a risk factor for the development of additional problems including other psychiatric disorders, substance misuse difficulties and problems with employment and relationships'.* Sadly, this appears like a very prescient prediction of how Jesse's life would play out.

5.2.23 The discharge from CAMHS without acceptance of a referral into Adult Services meant there was no transition into adult services. This was not helped by an absence at the time of adult ADHD services in Walsall or Lincolnshire, where Jesse went to university. The NICE guidance[20] appears to assume a seamless transition from CAMHS to adult services, but does not plan for less severe presentations like Jesse's, where he had been able to achieve reasonable educational outcomes.

5.2.24 *'A young person with ADHD receiving treatment and care from CAMHS or paediatric services should be reassessed at school-leaving age to establish the*

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[19] Dalsgaard, S., Østergaard, S. D., Leckman, J. F., Mortensen, P. B., & Pedersen, M. G. (2015). Mortality in children, adolescents, and adults with attention deficit hyperactivity disorder: a nationwide cohort study. The Lancet. Available at: www.thelancet.com/journals/lancet/article/PIIS0140-6736(14)61684-6/abstract [accessed 12 May 2015]

[20] NICE: para 1.1.4 Attention deficit hyperactivity disorder: diagnosis and management NICE guideline Published: 14 March 2018 www.nice.org.uk/guidance/ng87

need for continuing treatment into adulthood. If treatment is necessary, arrangements should be made for a smooth transition to adult services with details of the anticipated treatment and services that the young person will require. Precise timing of arrangements may vary locally but should usually be completed by the time the young person is 18 years'. See NICE's guideline on transition from children to adults' services for young people using health or social care services. [2008, amended 2018]

5.2.25 The DHR would argue that if a young person is still receiving ADHD medication prior to 18, it is surely acknowledgement that the ADHD will carry on into adult life and some form of 'hand over' seems prudent. It seems fair to observe that CAMHS and Jesse's GPs should have challenged the refused referral, and failing this, proactively attempted to ensure that university health services were aware of the situation in relation to adult ADHD support.

f. Learning point: A young person diagnosed with ADHD, still receiving medication, should be recognised as requiring a re-assessment before 18 and where necessary, a similar pathway to that offered to peers still receiving CAMHS support at 17.

Recommendation: The Black Country Healthcare Foundation Trust should ensure that ADHD services provided for children and adolescents recognise that when a patient of school-leaving age is discharged, there should be active consideration as to whether a patient should be referred to adult ADHD services and ensure that transition is achieved in line with NICE guidance. (This should also happen routinely, including where an adolescent is discharged and any subsequent ADHD provision within the next 12 months would more likely be provided by adult ADHD services.)

5.2.26 Although Jesse had received little effective support, he was able to complete A-levels and go on to university. This provided an opportunity to address Jesse's needs in a new environment, away from the pressures at home. The NICE guidance anticipates a proper handover between a specialist and an educational provider;

When ADHD is diagnosed, when symptoms change, and when there is transition between schools or from school to college or college to university, obtain consent and then contact the school, college or university to explain:

- *the validity of a diagnosis of ADHD and how symptoms are likely to affect school, college or university life*
- *other coexisting conditions (for example, learning disabilities) are distinct from ADHD and may need different adjustments*
- *the treatment plan and identified special educational needs, including advice for reasonable adjustments and environmental modifications within the educational placement*
- *the value of feedback from schools, colleges and universities to people with ADHD and their healthcare professionals.*

5.2.27 Although the GP confirmed the ADHD diagnosis to ULHS within 24 hours which was good practice, the complete absence of a transfer of Jesse's medical history put the university health services at a substantial disadvantage.

g. GP2GP patient record transfers remain a national problem with the two predominant IT systems used by GPs still failing to transfer records seamlessly. Health professionals should consider direct conversations to achieve a verbal 'handover' of key concerns relating to vulnerable patients.

Recommendation: Primary Care Services England should consider how GP2GP record transfers could be improved, and the Black Country & Birmingham West CCG should encourage as best practice direct conversations between GP practices where there are concerns that a vulnerable adult has changed practice

5.3 Adult ADHD support in Lincoln, Cornwall and Walsall (2013 to 2020)

5.3.1 The DHR acknowledged that the absence of an adult ADHD service in Lincolnshire significantly restricted the range of options open to ULHS health professionals. The ULHS IMR acknowledged that their GPs are not '*specialists in this area'*. The DHR would argue that the absence of adult ADHD support makes it even more essential that ULHS and A&E health professionals are

sufficiently trained and aware to recognise all relevant warning signs relating to adult ADHD. The evidence from this DHR is that at that time, they were not.

h. Learning point: CCGs should ensure that GPs and nursing staff have a clear understanding of the heightened risk of substance misuse disorders, DSH in adults with ADHD.

5.3.2 The first warning sign and a cause for concern, was Jesse's lack of engagement with ULHS. The IMR stated that '*the patient frequently did not attend GP appointments and was a frequent attender at out-of-hours services and A&E services which will have led to a lack of continuity of care*'. In a patient with a condition like ADHD, this should have caused the ULHS to be more vigilant to other indicators of risk and take steps to understand why Jesse was avoiding ULHS.

5.3.3 The chronology has illustrated how, taken as whole, during the period Jesse spent in Lincoln on his BA and MA courses, he was increasingly demonstrating signs of his impulsive behaviours and risk taking. There were eight Lincoln emergency department hospital presentations during his time there that included two DSH episodes (possibly three, with hindsight) and evidence that he was getting into violent confrontations linked to alcohol. Indeed, when he arrived in Lincoln to take up his studies in December 2013, he was still being treated for a broken jaw sustained in a fight in Birmingham.

5.3.4 The ULHS IMR writer was asked to address question sixteen from the Terms of Reference relating to impulsive and aggressive behaviours that may manifest in a lack of self-control leading to risk taking behaviours. The ULHS IMR pointed simply to the episode described at section 4.2 paragraph 14, when Jesse became aggressive with the out-of-hours service when refused a repeat prescription.

5.3.5 The ULHS received discharge letters with sufficient detail to allow the IMR author to identify that Jesse was a victim of assaults twice and DSH on one occasion. These should have prompted more professional curiosity. In the context of a patient with ADHD, this should have been identified as a warning

sign. Whilst the ULHS IMR states there was no alcohol or drugs misuse identified, his health record make reference to his levels of alcohol use, suggesting an awareness of the danger of using Ritalin and consuming alcohol. With hindsight it seems very likely that heavy drinking was established over his years at university.

5.3.6 In relation to the alleged lost prescriptions, the IMR describes appropriate challenge but indicates more focus upon the risk that the drugs could be sold or fall into the wrong hands rather than awareness of the possibility that Jesse could be abusing Ritalin by obtaining additional medication dishonestly.

i. Learning point: CCG should ensure GPs and nurses are aware of signs that a patient with ADHD may be abusing methylphenidate medications.

Recommendation: The Black Country and West Birmingham CCG and Black Country Healthcare Foundation Trust should ensure practitioners are aware of the heightened risks when they identify co-morbidities of adult ADHD and alcohol or drugs misuse and that they respond appropriately.

5.3.7 In February 2017, after DSH using Ritalin, Jesse refused to take part in any review with ULHS. At this stage, even if prior warning signs had been missed, it does not seem unreasonable to expect that a GP would review patient notes to identify the level of concern.

j. Learning point: when GPs or nominated health professionals are reviewing discharge letters, it is critical that they are considered together with all known history and taking into account any reluctance to engage with services or other recorded vulnerabilities

k. Learning point: Student health services are used to frequent alcohol related injuries in their population. They should however be alert to the danger of becoming complacent or failing to link the reported incident with other vulnerabilities.

5.3.8 The ULHS IMR indicated how the ULHS medical centre and the SWS should liaise together to offer support for a student with ADHD. They described best practice. 'We *liaise closely with University of Lincoln Student Wellbeing Service*

(SWS) to offer support to patients with ADHD. We use clinical meetings to discuss case studies and any student we have concerns about. In the case of symptoms suggestive of violent or impulsive behaviour, we would encourage further discussion around this patient and the services involved in their care and raise a safeguarding concern if appropriate'.

5.3.9 No evidence was offered to the DHR that any discussion occurred between SWS and ULHS in relation to Jesse. If it had, the professionals would have become aware of the SWS history: mental health and relationship concerns, Jesse's identification of a need for anger management support and his struggles on an academic front. This DHR would argue that such a discussion was vital and the failure to follow best practice was a missed opportunity to offer further support and evaluate risk from a safeguarding context.

5.3.10 The DHR would acknowledge that support for an existing condition like ADHD can be offered, but if it is declined by an adult that is their right. It is to be hoped, however, that professionals display compassionate persistence, recognising that refusals could indicate shame, anxiety or denial. In Jesse's case, Anika was clear that she felt he did not want to know what was wrong with him and did not like others to know how much he was struggling. He believed with some pride he was 'high functioning' in relation to alcohol and ADHD. The chronology would suggest that this represents wilful denial and self -delusion on Jesse's part.

5.3.11 When Jesse left England for Prague, he left behind his history and it was very unlikely his ADHD would be addressed. His drinking became problematic, and he lost his first employment because of it. His behaviours were becoming more impulsive and chaotic, and it was on his return trips to England in late 2017 and early 2018 that Francis and Hazel were left to try and seek help for his combined ADHD, alcohol misuse, and deteriorating mental health.

5.3.12 Hazel was clear that Jesse knew that he should not drink with his medication but from mid-morning when he awoke, he would start to drink heavily. Anika and Hazel both remembered how Jesse would describe himself with a degree of pride as a functioning alcoholic, contrasting himself with his father.

5.3.13 With hindsight, it is clear that Hazel and Francis were ill-equipped to deal with adult ADHD and Jesse's increased vulnerability around mental health, alcohol addiction and DSH. Francis himself sought help from the GPs describing his concern for Jesse, anxiety about the deteriorating home circumstances, but also his fear for himself. The practice would have received notification letters from `Liaison and Diversion' (January 2018) and the discharge letter from the CPN MHLT at Walsall Hospital (February 2018).

5.3.14 March 2018 saw the first attempts to get a referral for Jesse to the AAAS. The GP surgery would have been able to provide a detailed referral that described the social and environmental factors relevant to Jesse and which included the fear of violence in the home and concerns over his use of alcohol. The DHR has been unable to confirm whether the referral included this level of detail, whilst the DWMHT IMR was clear it did not.

5.3.15 Jesse was absent in Cornwall from May to October 2018, affording his parents some respite from the anxiety. However, Hazel was still pushing for mental health support (whether from AAAS or MHLT) and in June, Jesse gave consent to his Cornish GPs for information to be shared with Hazel. If the surgery had a conversation with Hazel about how their patient, Jesse, was presenting, it is not evident in notes available to the CCG panel member or in the CCG IMR.

5.3.16 The challenge of treating substance misuse and adult ADHD will be addressed below. There is no evidence that Jesse ever engaged with substance misuse services and, with one exception in 2016, no evidence from medical notes that a referral was suggested. The GP's records of Jesse's alcohol consumption suggest he was not forthcoming about the extent of his drinking, claiming to drink only 2/3 units a week. Only during GPs attendances after the homicide did Jesse acknowledge the extent and duration of his alcohol misuse. It seems very unlikely that Francis would not have mentioned Jesse's alcohol issues in conversation with the GPs. In any case, alcohol-related incidents were scattered through Jesse's past history.

5.3.17 From the scant information in the Walsall surgery notes there is very little evidence that, at the point of referral to the AAAS a year later, the surgery had

identified whether the combined risk from alcohol misuse and Ritalin abuse remained an issue, although with hindsight it was. It should surely have informed the referral. The DWMHT IMR was clear that: '*The GP referral to the AAAS only reported a historical DSH incident; there was no relevant information provided regarding the perpetrator's social circumstances and special needs'.*

Recommendation: The Black Country & Birmingham West CCG should remind GPs that a referral made to a service should include a detailed description of a patient's vulnerabilities (rather than rely on self-disclosure) and should be updated with any relevant new information affecting vulnerability and risk, if there is a significant delay between the referral and the patient's first appointment.

5.3.18 The situation was not helped by the fact that the AAAS would apparently not have been able, in mid-2019, to view electronically previous assessment by the Diversion & Liaison team and MHLT. Although this problem has since been rectified by the Trust, with a shared IT system since late 2020, the DHR would suggest that it should not have been allowed to cause an information-sharing problem and subsequent failure to understand a patient's needs, given that the MHLT, Diversion & Liaison and AAAS were teams within the same Trust.

5.3.19 The AAAS knew of the patient referral for several months before the assessment and it should have been possible in that timeframe to obtain scanned or emailed copies of records or GP discharge letters. Jesse was a self-confessed '*chronic alcoholic'* who had neither sought nor received support at any time in his adult life. His substance misuse was of long standing and included cocaine use. It is clear that Jesse continued to use alcohol and cocaine until his suicide a year later. This was probably his major presenting vulnerability and yet the AAAS team had not taken it properly into account. The only reference to alcohol in either assessment was ironically when Jesse accused his father of 'drinking too much and this caused problems'. Jesse declared that his ADHD did not cause relationship problems.

l. Learning point: Mental health assessments (including for ADHD) should always be informed by a complete health history and by any previous assessments.

Recommendation: The Black Country Healthcare NHS Trust should ensure that practitioners at AAAS are able to access a comprehensive history detailing any involvement and assessments by other mental health teams when a patient is new to service and that they avoid an over-reliance upon patient's self-disclosure.

5.3.20 Jesse refused all family involvement in the process which should have raised concerns and prompted further enquiry to understand the social and environmental factors that had not been shared by the GP.

5.3.21 Jesse left the two sessions with AAAS in August, having adjusted his medication to include Medikinet, a proprietary brand of modified-release methylphenidate. The deep-seated problems caused by adult ADHD, it is suggested, remained unresolved.

6 Co-morbid Presentations and Adult ADHD

6.1 The treatment of ADHD is complex in itself, but the presence of co-morbidities greatly complicates the issue and science's understanding of the inter-relation of these co-morbidities develops all the time. This DHR acknowledges that GPs, CPNs, are not experts in ADHD, but some greater basic awareness of co-morbidities may mean that rather than simply recording and noting signs, they will react to them by engaging in conversations with patients, and where appropriate their families and friends. More particularly, they will hold multi-disciplinary team meetings or conversations with other professionals to get a fuller picture of the patient. In this case it was hard to identify any shared assessment of what the presence of the co-morbidities meant for the treatment of Jesse.

m. Learning point: Primary care (GPs) and secondary care (mental health) staff and those in hospital emergency departments, need to develop a greater awareness of likely co-morbidities with ADHD and their impact upon the patient, their families and treatment plans.

6.2 Studies in adults and adolescents have found ADHD to be associated with earlier initiation and higher rates of substance misuse: alcohol 33-44%, cocaine 10-35%[21].

6.3 It is clear that alcohol was a major factor in this case and Jesse had admitted to using cocaine but said he now was a 'social' user, suggesting therefore that there was likely to have been a period of significant use of both a stimulant (cocaine) and a depressant (alcohol). It is vital that professionals are aware of the risk of coca-ethylene when alcohol and cocaine are abused. Combining in the liver and moving into the blood stream it can affect vital organs causing strokes and heart attacks. It also leads in many cases to impulsivity.

6.4 There is some evidence for an association between DSH and ADHD which suggests that ADHD may be a potential risk factor for DSH.[22] The evidence linking hyperactivity, impulsivity and aggression in ADHD to DSH, is developing.[23] In this case DSH was a repeated pattern in adult life. There were more DSH episodes than were known to professionals and tragically they were a warning of the risk of suicidality in this case. Hyperactivity and an inability to sleep was one of the reasons Anika felt Jesse drank so heavily as a self-medication which is a known motivation for alcohol abuse in adolescents and adults with ADHD.

6.5 With hindsight, it is clear that Jesse experienced the most common additional vulnerabilities that impacted upon his ADHD but also his willingness to address both his ADHD and addiction. Significant challenges exist in assessing and treating ADHD in the context of substance misuse and the difficulties are illustrated in this case.

6.6 The DHR has shown that Jesse did not receive particularly effective childhood ADHD support and was discharged as an adolescent, before a transition into adult services

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[21] Rakesh Magon and Ulrich Muller ADHD with co-morbid substance use disorder: review of Treatment

[22] Clare S. Allely: The association of ADHD symptoms to self-harm behaviours

[23] J.H.Dowson and A.D.Blackwell Department of Psychiatry University of Cambridge Impulsive aggression in adults with ADHD

was achieved. In 2013, this was because the referral was not accepted, due to lack of a confirmed ADHD diagnosis. In the two areas that he spent his early adult years (Lincolnshire and Walsall) services were either not provided, or in their infancy. Jesse was not pushing for help; in fact he tended to avoid engagement unless on his terms. The absence of established pathways, it is argued, allowed Jesse to 'slip through the cracks', confident that his continued use of alcohol and his ADHD was not really impacting upon his relationships. Francis and Hazel would have disagreed.

6.7 His heavy use of alcohol was known, but in spite of some contact in the years under review with mental health services, specialist ADHD secondary services and primary care, there is little sense of a shared treatment plan, agreed with Jesse and known to his family, who were trying to support him.

6.8 Magon and Muller's study (already cited) suggested that a period of total abstinence from substance misuse for three months, together with cognitive behavioural therapies provided the best pathway to treatment for ADHD and substance misuse.

6.9 It is hard to avoid the conclusion that there was only limited professional understanding of the real social and environmental factors in Jesse's life and only very partial identification of co-morbidities with ADHD. The adult support offered required an understanding of the impact Jesse's ADHD and use of alcohol was having on the family supporting him. There had been opportunities to gather this information and available records suggested some of the issues, but Jesse's refusal to involve the family and the resentment he felt for Francis was likely to lead to further conflict.

Recommendation: The Black Country and West Birmingham CCG and Black Country Healthcare Foundation Trust should ensure practitioners are aware of the heightened risks when they identify co-morbidities of adult ADHD and alcohol or drugs misuse and that they respond appropriately.

7 Conclusions

7.1 This case emphasises the crucial need for professionals to take a 'Whole Family or Think Family' approach in relation to mental health, ADHD and safeguarding.

7.2 During Jesse's childhood and adolescence, ADHD services as they existed then, achieved little understanding of Jesse's support network nor did they provide services Jesse and his whole family were willing to engage with. There was a failure to understand the dynamics of the family or the vulnerabilities of those supporting Jesse, particularly Francis.

7.3 Jesse's ADHD continued into adulthood and with it came many of the common comorbidities, drug and alcohol misuse, mental health concerns and deliberate self-harm. Jesse was able to move into Higher Education without any agreed support plan because the harmful impact of his ADHD had not been properly identified as a child. Faced with the stresses of adult life, his ADHD manifested in aggression, violent episodes, and deliberate self-harm. There was a repeated failure by services to see the bigger picture. There is little doubt that as an adult, Jesse was reluctant to address either his ADHD, or the comorbid issues of alcohol, cocaine, self-harm and depression. This was even more reason for services to identify the additional risk to both Jesse, but also his immediate family.

7.4 Jesse's family were left coping with a worsening mental health situation, facing the frustrations felt by many when vulnerable adults refuse permission for information to be shared with their family or carers. They did not understand their rights as 'nearest relatives' under the Mental Health Act nor did they know how to respond to Jesse.

7.5 When Jesse was finally assessed by AAAS, work was not informed by a proper understanding of recent history, risk, or the perceptions of those closest to the service user. This must be seen as a missed opportunity to intervene to support Jesse and his whole family and is even more frustrating when it is considered how long it had taken to get Jesse to that point.

7.6 It is crucial that appropriate agencies in Walsall consider the lessons from this DHR and review service provision, policy procedures and guidance and training in relation to child and adult ADHD to ensure professionals are better able to support service users and their families and carers.

8 Recommendations

8.1 The Black Country and West Birmingham CCG should ensure that practitioners are confident to identify the **signs and risk of intra-familial domestic abuse** and that referral pathways are identified when a victim is a parent, and the offender is an adult.

8.2 The Black Country & Birmingham West CCG should remind GPs that a referral made to a service should include a detailed description of a patient's vulnerabilities (rather than rely on self-disclosure) and should be updated with any relevant new information affecting vulnerability and risk, if there is a significant delay between the referral and the patient's first appointment.

8.3 The Black Country Healthcare Foundation Trust should ensure that ADHD services provided for children and adolescents recognise that when a patient of school-leaving age is discharged, there should be active consideration as to **whether a patient should be referred to adult ADHD services** and ensure that transition is achieved in line with NICE guidance. (This should also happen routinely, including where an adolescent is discharged and any subsequent ADHD provision within the next 12 months would more likely be provided by adult ADHD services.)

8.4 The Black Country Healthcare NHS Trust should ensure that practitioners at AAAS are able to **access a comprehensive history** detailing any involvement and assessments by other mental health teams when a patient is new to service and that they avoid an over-reliance upon patient's self-disclosure.

8.5 The Black Country & Birmingham West CCG and The Black Country Healthcare Foundation Trust should ensure that current provisions of **child ADHD services are age appropriate** and should audit to identify the extent to which services meet the NICE Guidance in relation to identifying the impact of ADHD upon the whole family. These agencies should be able to describe how a 'Whole Family 'approach can be evidenced in ADHD services.

8.6 The Black Country and West Birmingham CCG and Black Country Healthcare Foundation Trust should ensure practitioners are aware of the heightened risks when they **identify co-morbidities of adult ADHD and alcohol or drugs misuse** and that they respond appropriately.

8.7 The Black Country & Birmingham West CCG and The Black Country Healthcare Foundation Trust should agree a protocol to ensure that every child or adolescent prescribed ADHD medication is offered **a consultant-led review of the need for continued medication into adulthood.**

8.8 Primary Care Services England should consider how **GP2GP record transfers** could be improved and the Black Country and West Birmingham CCG should also encourage as best practice direct conversations between GP practices where there are concerns that a vulnerable adult has changed practice.