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

EXECUTIVE SUMMARY

DOMESTIC HOMICIDE REVIEW

in respect of

D

Born 1948

Chris Few
December 2015

Contacting the Council:
Switchboard 01782 717717 · Fax 01782 711032 · DX 20959 · Text 07800 140048
E-mail webmaster@newcastle-staffs.gov.uk · www.newcastle-staffs.gov.uk

INTRODUCTION

1 Summary of Circumstances Leading to the Review

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

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

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

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

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

2 Terms of Reference

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

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

- The mental health of D and the effectiveness of services to address any needs, including those of any informal carer, associated with this
- The mental health of G and the effectiveness of services to address any needs, including those of any informal carer, associated with this
- The potential impact that involvement with the British Army of D and/or G may have had on events leading to D's death.

3 Review Process

3.1 The Review Panel was chaired and the Overview Report was written by Chris Few, an Independent Consultant.

3.2 The Review Panel comprised the following post holders:

- Personal Support Officer
  Army Welfare Service

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

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

- Trust Safeguarding Lead
  North Staffordshire Combined Healthcare NHS Trust

- Principal Community Safety Officer
  Staffordshire County Council

- Senior Investigating Officer
  Staffordshire Police

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

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

3.3 Management Review and Summary Information Reports were submitted by:

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

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

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

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

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

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

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

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

4 Family Engagement

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

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

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

FINDINGS AND CONCLUSIONS

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

5.2 Z, D and G appear to have been a close knit family with few interests outside of their home and receiving few visitors. There had been a verbal argument between D and G two years prior to D's death but there had never been any incidents of physical violence and they were reported to have been tolerant towards each other.

5.3 Nothing was brought to the attention of any agency in the 11 months prior to the killing of D which might have suggested that it would occur.

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

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

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

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

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

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

5.10 Between 1966 and 1985 D served with the British Army. Consequent to his experiences in the Army D from suffered from PTSD. The treatment provided to him for this condition was appropriate. The Review found no indication that D's Army service or his PTSD played any part in the attack which led to his death.

5.11 There is similarly no indication that G's involvement with the Territorial Army between 1989 and 1994 contributed to the deterioration in his mental health or played any part in him killing D.

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

RECOMMENDATIONS

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

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

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

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