Domestic Homicide Review

- Executive Summary –

Commissioned by

London Borough of Ealing

Victim: "John"

Died July 2020

Independent Chair

& Report Author: Stephen Roberts QPM, MA (Cantab)

Completed: September 2023

-Executive Summary-

Contents

The Review Process

1.1 This summary of an Overview Report of a Domestic Homicide Review examines the circumstances surrounding the death of John, who died at the hand of his son, Paul, in July 2020. Paul had a significant history of mental illness. The review will thus focus on the support offered to Paul and the manner in which relevant agencies coordinated their responses to events as they unfolded.

1.2 In addition, the review will examine the actual and potential operational coordination between agencies.

1.3 The DHR was formally commissioned by the Ealing Community Safety Partnership in September 2021 (some 14 months after the homicide). It is understood that this delay was at least partly because the homicide was initially viewed as primarily due to issues within the mental health sphere rather than being a domestic homicide, even though it was known from the outset that the victim and perpetrator were father and son. The classification of the homicide as being principally related to mental health provision resulted in the prompt commissioning of a Level 2 Homicide Report by the West London NHS Trust. Overstretch following the COVID pandemic also contributed to the lack of prioritisation of the case.

1.4 All agencies were asked to secure whatever material they might have to contribute to the review and, where appropriate, commence their own Individual Management Reviews (IMR).

1.5 Paul was arrested shortly after the homicide. When he was taken to a police station he was examined by two suitably qualified psychiatrists and an Approved Mental Health Practitioner. The experts concluded that Paul showed no signs of acute mental health relapses, that consequently he was not detainable under the Mental Health Act but was fit to be interviewed by police and enter the criminal justice process.

1.6 In June 2021, Paul pleaded guilty to the manslaughter of his father, John by reason of diminished responsibility. He was made subject of an order under section 37/41 of the Mental Health Act (i.e., that he be detained in a secure mental health facility)

1.7 Completion of the review was considerably delayed beyond the six-month limit specified in the guidelines. These delays were the result of particular factors:

- The time taken to negotiate and arrange discussions with family members and friends.
- The time taken for the trial of Paul to be completed.
- Delays in an effort to secure an interview with Paul – which ultimately did not take place.
- Additional complexities regarding access to records and individuals as a result of the pandemic/lockdown.

Despite these difficulties, the West London Mental HealthTrust, which was responsible for the treatment of Paul's mental illness, completed its very detailed and thorough review by October 2020, i.e. within 3 months of the homicide. The contents of the NHS review provided a substantial body of evidence to this DHR.

Contributors to the Review

1.8 On notification of the homicide, local agencies were contacted and asked to check their involvement with John and/or Paul and to secure their records. Those agencies that reported having no contact with either John or Paul prior to the homicide included:

Victim Support

LBE Community Safety Unit

Clinical Commissioning Group

1.9 IMRs were requested from:

The Metropolitan Police

West London Mental Health Trust (WLMHT) – the Trust provided a copy of its Level 2 Homicide Review, completed October 2020

The IMR and Level 2 Review were of a particularly high quality and content.

Catalyst Housing Ltd. Provided limited information regarding tenancies, having no other relevant information

LBE Adult Social Care had only trace information on Paul, which had already been provided by Police or in the WLMHT review report.

In addition, information drawn from the police homicide investigation was provided on request, together with relevant policy instructions relating to police involvement in providing support in mental health incidents.

Family, Friends, Work Colleagues and Wider Community

1.10 Paul's parents lived separately and relations between the two sides of the family were somewhat distant. Although living separately, Paul's parents both took an interest in Paul, albeit they had differing views on the best way to support their son. Paul's mother very much welcomed the support of health agencies whereas John believed that a less interventionist approach would have benefited his son. John appears to have had a somewhat chaotic lifestyle and apparently had no fixed address. Paul had his own flat in Ealing but frequently stayed in his mother's house which is also in Ealing. John occasionally stayed at Paul's flat in Ealing and in fact was doing so at the time of the homicide, although this was unknown to Paul's mother.

1.11 The review process undertaken by WLMHT included extensive discussions with Paul's family. The Independent Chair also interviewed Paul's mother but did not intrude on the privacy of the wider family on the basis that their views had already been gathered by WLMHT. The Chair's interview with Paul's mother focused chiefly on the extent of cooperation between agencies (police and health) when she believed that Paul was approaching or having mental health crises.

1.12 At his criminal trial Paul had the full benefit of legal representation and extensive expert assessment of his mental health. He pleaded guilty to manslaughter of his father but his mother remains unable to accept his guilt and believes (unnamed) others committed the offence. The MPS Homicide Investigation Team have no evidence to support this view.

The Review Panel Members

1.13 An independent Review Panel was established. Review Panel members were of the appropriate level of expertise and were independent, having no direct line management of anyone involved in the case. As a result of the preliminary view of the homicide as a mental health incident, the panel did not include representatives of either mainstream health or an independent Domestic Abuse charity. Whilst subsequent enquiries supported the initial view, it is a matter of regret that this

degree of independence was not incorporated – future panels should ensure the mistake is not repeated.

1.14 The Review Panel members were:

Name	Job Title	Agency
Stephen Roberts	Independent Chair	
Justin Armstrong	Specialist Crime Review	Metropolitan Police
Nicola Dymock	Community Area Manager	Catalyst Housing Ltd
Jacky Yates	Assistant Director	Adult Social Care
Tracy Harrington	CEO/Director	Community Activities Project Ealing
Joyce Parker	Community Safety Team Leader	London Borough of Ealing
Ahenkora Bediako	DCI Public Protection Lead	Ealing Police Senior Leadership Team

Independent Chair & Report Author

1.15 Stephen Roberts, QPM, MA (Cantab), was appointed by the Ealing Community Safety Partnership as Independent Chair of the Review Panel and Report Author. He is a former Deputy Assistant Commissioner of the Metropolitan Police (retired 2009), now working as a private consultant. He has extensive experience of partnership working at borough and pan-London level. He is a former Director of Professional Standards and subsequently Director of Training and Development for the Metropolitan Police. He is entirely independent of the community safety partnership and all other agencies involved in this review. He has completed training for the role (including an update for the 2016 Guidance) and has successfully chaired and authored domestic homicide reviews for other community safety partnerships.

Terms of Reference for the Review

1.16 In establishing the terms of reference for this DHR, care was taken to avoid a duplication of the work and findings of the prior WLNHS Trust review. Such duplication would have entailed unnecessary expenditure and, more significantly, renewed the traumatic impact of the tragedy on friends and relatives. The review was therefore guided by more limited terms of reference, viz:

- To establish what lessons may be learned from the case regarding ways in which local professionals and agencies worked individually and collectively to safeguard victims.
- To determine how those lessons may be acted upon.
- To examine and where possible make recommendations to improve risk management mechanisms within and between all relevant agencies.
- To identify what may be expected to change and within what timescales.
- To assess whether the relevant agencies have appropriate and sufficiently robust procedures and protocols in place and the extent to which they are understood and adhered to by their staff.
- To improve service responses including, where necessary, changes to policies, procedures and protocols.
- To enhance the overall effectiveness of efforts to reduce domestic violence and its impact on victims through improved inter and intra agency working.
- To maximise opportunities for fast time learning and overall partnership improvements as well as medium- and longer-term enhancements.
- To examine and make recommendations if appropriate to improve the accessibility of safeguarding services to isolated ethnic minorities.

Summary Chronology

1.17 The principal subjects of this report are the victim and perpetrator referred to as "Paul" and "John" whose identifying particulars are:

Paul	Born: London, 1983	Resident of Ealing	Black, British	No known religious affiliations
John	Born: Grenada, 1960	No fixed address	Black, British	No known religious affiliations

1.18 John appears to have had a somewhat chaotic lifestyle, as a result of which, it proved impossible to trace friends who might have been able to provide a clearer account of his character and habits. He had been convicted of a variety of offences. Police records indicate that in November 2018, John was ejected from a flat in which he had been living. He was initially placed into temporary accommodation but subsequently became homeless, possibly "sofa-surfing". Police records show him as being "of no fixed abode". It is entirely unclear whether John was a resident or visitor at Paul's address. It is known, however, that Paul frequently lived at his mother's address.

1.19 The focus period for this review is from 2015 to July 2020 (the date of the homicide). This period encompasses the majority of Paul's detentions by Police under section 136 of the Mental Health Act 1983 (MHA). It should be noted, however, that Paul's engagement with secondary mental health services dates back to 2001 when he presented to a Community Mental Health Team (CMHT) suffering from anxiety, depression and auditory hallucinations. Overall, Paul had approximately 10 admissions to hospital under sections 2 or 3 of the MHA due to relapses in his mental state, often caused by his non-concordance with his medication.

1.20 In June 2015, Paul was detained by police under section 136 of the MHA. He had been acting aggressively towards his mother and she called for police assistance. He was persuaded to leave his mother's house but continued to act aggressively and was eventually handcuffed and taken to hospital where he was admitted to a ward but continued to be non-compliant to the extent that police

officers needed to help hospital staff to restrain him. The incident was properly recorded, assessed and the information shared with LBE Adult Social Care. In December 2015 police were again called to Paul's mother's address where he was throwing his belongings out of the windows. LAS staff had been unable to persuade Paul to go with them to hospital. When officers approached him, he refused to engage and walked away from the house. The officers felt that he appeared fit and healthy, but they believed his mother needed more support. A MERLIN[1] entry was created and shared with LBE Adult Services. In 2017 he was again detained by police when he was found running naked in the street. After the ensuing period of treatment, he was discharged on a Community Treatment Order (CTO) which set out compulsory medical treatment and allowing a mechanism of swift recall to hospital if needed. In November 2018 he was recalled on his CTO due to a relapse and discharged in January 2019. At that time the CTO was reset within the discharge procedure. Following a period of stability with Paul remaining concordant with his medication, he was discharged from his CTO.

1.21 During the period January to July 2020, Paul attended clinic on a planned basis every 3 – 4 months. His diagnosis, which had been unchanged for a decade remained: bipolar affective disorder, currently in remission plus mental and behavioral disorders due to the use of cannabinoids/harmful use. He was assessed in terms of the risks of harm to others. It was noted that he had assaulted his mother in 2015 and that his case had been referred to the MAPPA (the Multi Agency Public Protection Arrangements) panel, albeit no further action was decided upon.

1.22 In early January 2020 Paul was seen at the Ealing Recovery Team East (ERTE) office for his depot injection (a slow-release form of medication which is used to enable antipsychotic drugs to be released into the body over an extended period). The nurse dispensing noted that Paul seemed "guarded" but concordant. That month Paul was reviewed in the outpatient clinic. He presented well and was positive for the year ahead. He was apparently well

[1] An MPS system used to record details of persons considered vulnerable for some reason who have come to the notice of police officers. The system enables sharing of such information with other local agencies.

kept, engaged in an educational course and staying with his mother. At the end of the month, Paul attended for his planned depot injection.

1.23 By early April 2020, COVID restrictions were in place and Paul's scheduled outpatients review appointment was conducted by telephone by his usual Consultant Psychiatrist. He presented as settled and no changes were made to his overall management plan. The focus of the consultation was on how Paul was coping under the lockdown restrictions. He was staying with his mother and was aware of how to contact services should he require any additional support. Throughout April, May and June Paul attended clinic for his monthly depot injections and on each occasion the nurses noted that he showed no sign of mood disturbances or psychotic features.

1.24 In mid-July 2020 in the evening Paul's mother called Police, saying that Paul was throwing things at her, had mental health problems and that she needed him to go to hospital. MPS records indicate that the message was relayed to the London Ambulance Service (LAS) to ensure attendance by both agencies. Paul apparently refused to be seen by LAS staff and was unwilling to engage with the police officers. The officers noted that though it was possible that Paul may become worse overnight, at the time he seemed mentally and physically well. One of the officers attending completed a MERLIN entry and after proper assessment this was shared with LBE Adult Social Care.

1.25 The records of this same incident held by the West London Mental Health Trust (WLMHT) indicate that having called Police, Paul's mother then called the ERTE Duty Worker for advice and to ask that Paul be given an urgent depot injection. She was told to relay the information to the police. Paul was already due for a depot injection on the following Wednesday but as a result of the call, this was rescheduled for a day earlier, together with an additional outpatient appointment the same day. The ERTE Duty Worker was later contacted by LAS staff who explained that there appeared to have been a breakdown in the relationship between mother and son, but that Paul presented as having capacity. It was agreed that ERTE would follow up with Paul the following Monday (i.e. immediately after the intervening weekend). An e-mail was sent to Paul's Care Coordinator and the Duty Senior to update them. **Although the ERTE Team Manager sent a message to the incoming Duty Team on the Monday, there is no record that a member of the Duty Team actually contacted Paul, as previously planned.**

1.26 There are no WLMHT records covering the weekend following the above incident, however on the Sunday evening, Paul's mother again called the police. She told the Operator that, "My son is mentally ill, and he is slamming the door in the house and saying he will put me where I need to be. I am scared as he is saying crazy things". Police officers attended and after speaking to mother and son, concluded that there had been no physical violence used or implied and that since Paul was prepared to leave and his mother wanted him to go, he was allowed to leave. The officers completed a DASH assessment and recorded the matter as a non-crime incident. *A number of subsequent failures of internal MPS procedures were identified during the IMR process. They have been addressed by the MPS but they could not have had a bearing on the eventual homicide and are thus, are not relevant to this review.*

1.27 The following Monday Police received a number of calls as a result of which they forced an entry to a flat in Acton where they discovered the lifeless body, subsequently identified as John, who had died as a result of loss of blood from multiple stab wounds. The flat was Paul's usual home when not staying with his mother.

1.28 Later that evening LAS received a call to an unconscious male who had been found collapsed in the road. Once in the ambulance, Paul identified himself and told the paramedics that he had been training for the marathon race. He was taken to Ealing Hospital but shortly thereafter he left the hospital.

1.29 Sometime later police received numerous 'phone calls about a male acting erratically, assaulting members of the public and jumping in and out of the traffic. Officers chased the man, but he climbed onto the roof of Ealing Fire Station and refused to come down. Officers were able to identify the man as Paul and after a stand-off lasting nine hours, he was talked down and arrested for the murder of his father.

Key Issues Arising from the Review

1.30 The case history indicates a number of emerging themes:

- The exercise of police powers when dealing with people suffering from mental ill-health.

- The operational effectiveness and efficiency of arrangements within and amongst agencies to deal with out-of-hours crises.
- Defects in service delivery both to Paul and to his family by the mental health agency

1.31 The WLMHT concluded in its Level 2 Review that the root cause of the tragedy was the relapse of Paul's mental illness. This conclusion is not without difficulties, however. It is noteworthy that after his arrest shortly after the homicide, Paul was assessed by two properly qualified psychiatrists and an Approved Mental Health Practitioner. Their joint conclusion was that Paul showed no signs of acute mental health relapse.

1.32 This assessment contrasts with the conclusion at Paul's trial 11 months later, made on the basis of the expert evidence agreed between Defence and Crown forensic psychologists/psychiatrists. The verdict of manslaughter due to diminished responsibility implies that Paul must have suffered from an abnormality of mental functioning (due to his mental illness) which substantially impaired his ability to understand his conduct, form a rational judgement or exercise self-control.

1.33 The overall conclusion of this review is thus that the tragedy occurred because of Paul's mental illness which the combined agencies were unable to manage effectively or safely.

1.34 The WLMHT identified a number of problems with Paul's care and management in the period immediately before the tragedy:

- Paul was not followed up by the Duty Team on 20th July 2020 as planned when his family raised concerns on 17th July. The failure was due to an unclear local handover/updating practice – the task of requesting a follow up was e-mailed through to the Duty Team rather than being logged on the Duty System calendar as was a more standard local expectation (see Recommendation 1)
- The family's use of the available crisis plan to escalate their concerns did not lead to a resolution prior to the tragedy, despite contacting several services for support including police, the Crisis Team Single Point of Contact and LAS – it appears each agency followed its own protocols, but the combined effect did not lead to a safe resolution (see Recommendation 2)

- WLMHT should have been more proactive in exploring and offering support to Paul's carer (his mother) – Paul's mother suffered from arthritis and Paul often lived with his mother to help her around the house. Despite this, Paul had not explained the details of his care plan to his mother or disclosed that his father, John, was living in Paul's house at the time. Paul was very private about his care and did not want family involvement in his care planning meetings. There is, however, very little evidence of efforts by ERTE staff to persuade Paul to allow greater family involvement in his care planning. (see Recommendation 3)

- Poor record keeping in the context of risk assessment – Paul's last documented risk assessment was in December 2018 and was not well-focused on the risk he might present to the community. It was noted, however, that the system of electronic risk assessment was changing to a new format and that Paul's presentation had not changed since his last assessment. (see Recommendation 4)

1.35 The WLMHT identified the overall ineffectiveness of the crisis plan, despite the fact that each agency followed its own procedures. Police Officers are granted powers under section 136 of the MHA. Where a person appears to be suffering from a mental disorder and to be in need of immediate care or control, a constable may, if he thinks it necessary in the interests of that person or for the protection of others, remove that person to a place of safety. The power is, however, limited and cannot be exercised in any house, flat or room where that person or another person is living. The limitation on the use of this power restricts its use in circumstances such as this case where officers, on different occasions, found Paul either in his mother's house (and thus not detainable) or in the street, having left the house but at which time he did not appear in need of immediate care or control.

1.36 The complexities of legislation and processes for dealing with mentally disordered people are difficult for officers to employ. Officers are now provided with a "Mental Health Toolkit" to assist them. *The toolkit is extremely detailed but extends to 121 pages*, which are available to officers via their Service IT. The practical reality is that, especially at weekends and public holidays, when there is often very limited cover from mental health professionals or capacity for emergency admissions, police officers and paramedics are required to manage mentally ill people armed with little more than their own judgement and powers of persuasion. Improved joint planning and information sharing between agencies is

a necessary stop gap (see Recommendation 2) but the status quo is clearly unsatisfactory and merits a legislative review (see Recommendation 5).

Conclusions & Lessons to be Learned

1.37 The principal lessons to be learnt from this case may conveniently be grouped under four main headings:

- Improved information management within WLMHT
- Greater emphasis on engagement with actual and potential carers within a patient's family/friends
- Operational coordination between agencies
- Legal powers available to police and other agencies
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1.38 **Improved information management within WLMHT –** standardised systems are needed to ensure that messages and taskings risk-related documentation are created and transmitted in consistent way to ensure that all staff are aware of what needs to be done and how to task/inform colleagues (Recommendations 1, 2 and 4 address these issues).

1.39 **Engagement of actual & potential carers** – the active support and assistance of carers has been shown to improve outcomes for patients. WLMHT staff should therefore make every effort to persuade patients and others to participate (Recommendation 3 addresses this issue).

1.40 **Interagency operational coordination** – mechanisms are needed to ensure joint planning between agencies and information sharing where there is a likelihood of mental health crises occurring (Recommendation 2 addresses this issue).

1.41 **Possible legislative change** – This review highlights the inadequacy of currently available legal powers to enable police and other agencies to deal safely and effectively with some of those suffering from mental health crises (Recommendation 5 addresses this issue).

1.42 There were identified shortcomings in the management of Paul's mental health. The recommendations below seek to address those shortcomings within WLMHT and are drawn from the NHS Root Cause Analysis report. Whilst there were clear signs that Paul was having or approaching a relapse, this review has found no evidence that the tragic outcome could or should have been predicted.

1.43 Police and LAS staff were called upon to deal with a critical situation on the Friday evening before the homicide. Police officers and LAS staff acted within their powers and separate organisational guidance but despite this, they were unable to manage Paul effectively or safely. The case highlights the need for a wider review of the powers available to both agencies at a national level but in the more immediate future there is a clear need for local agencies to develop clearer information sharing, planning and coordination measures to enable more effective, safer management of those with mental health crises – the need for such development is heightened by the recent announcement by the MPS Commissioner that as from August 2023, MPS officers will no longer attend mental health incidents unless lives are at risk. This case amply illustrates that identifying which cases are actually life threatening is a somewhat challenging task and one with which mental health professionals themselves struggle.

1.44 Mental Health providers are responsible for ensuring that local service development plans are created and implemented in collaboration with people with mental health problems and their families or carers, as well as local mental health providers, public health providers and partner organisations. This should include voluntary and third sector organisations, drug and alcohol service commissioners and providers, and local authorities (social care, housing, debt, benefit advice, employment, and education) to provide a framework for collaborative action.

Recommendations

1.45 **Recommendation 1**

(a) WLMHT to implement a homogenous approach across the Mental Health Integrated Network Teams (known as MINT) to manage emergent tasks via local duty with a clear, standardised system to avoid potential confusion

(b) WLMHT is currently developing new policy and guidance as part of the transformation to Mental Health Integrated Network Teams. The new measures should be implemented as a priority

Recommendation 2

The local Integrated Care Commissioning Board should explore improved mechanisms for liaison, information sharing and operational planning in respect of individuals assessed to be at risk of mental health crises, especially where there is a history of violence (including domestic violence).

Recommendation 3

WLNHS to ensure that recovery teams offer support for all families and carers of clients with psychosis, as recommended by NICE guidance.

Recommendation 4

WLNHS to develop an ERTE system to ensure individual clinicians and their managers are alerted to any cases where risk assessments are falling out of date and that updates are audited.

Recommendation 5

Home Office and DHSS to consider instituting a review of legal powers and policy to improve the ability of agencies to safely and effectively manage those undergoing mental health crises.

Stephen Roberts QPM, MA(Cantab)

Independent Chair & Report Author