Domestic Homicide Review

- Overview Report -

Commissioned by

Ealing
Community Safety Partnership

Victim: "John"

Died: July 2020

Chair and Report Author: Stephen Roberts

Date Completed: June 2023

Contents

Preface

The Independent Chair and Review Panel would like to begin this report by expressing their sympathy to the family and friends of “John”.

The Independent Chair would also like to thank the Review Panel for their participation in this DHR.

This is a report of a Domestic Homicide Review (DHR) conducted under the terms of section 9 of the Domestic Violence, Crime and Victims Act 2004. The Act states that a DHR should be a review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by-

- A person to whom [they were] related or with whom [they were] or had been in an intimate personal relationship, or
- A member of the same household as [themselves],

with a view to identifying the lessons to be learnt from the death.

1. Introduction

1.1 This 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 way 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 A decision was made by the London Borough of Ealing (LBE) Community Safety Partnership to commission this review, following notification by the Metropolitan Police Service, because the circumstances of the homicide fell within the terms of the above legislation.

1.4 The review considers what has been learned of both John and Paul. Prior to the homicide, both men were known to various agencies.

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

1.6 A DHR does not take the place of the criminal or coroner's courts, nor does it take the form of a disciplinary process.

Timescales

1.7 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.

1.8 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).

1.9 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 NHS Trust, 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.

1.10 The Home Office provided notification and approval for publication on [TBC]. The Home Office letter is included in C.

Confidentiality

1.11 The findings of this DHR are confidential. Information is available only to participating officers/professionals and their line managers, until after the DHR has been approved by the Home Office Quality Assurance Panel and published.

1.12 As recommended by the statutory guidance, pseudonyms have been used and precise dates obscured to protect the identities of those involved.

1.13 The pseudonyms were chosen by the Independent Chair after consultation with a family member who expressed no view.

2. Methodology

Terms of Reference

2.1 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, including an examination of the metrics and management information mechanisms in relation to risk assessment and management.

- To improve service responses including, where necessary, changes to policies, procedures and protocols.

- To enhance the overall effectiveness of efforts to reduce domestic abuse and its impact on victims through improved inter and intra agency working.

- To maximize opportunities for fast time learning and overall partnership improvements as well as medium and longer-term enhancements.

2.2 The Review Panel agreed that the focus period for the review should be between 2015 and John's homicide in July 2020. Events outside this timeframe have been included in the review to provide an appropriate context.

Contributors to the Review

2.3 On notification of the homicide, local agencies were contacted and asked to check for their involvement with John and/or Paul and to secure their records.

2.4 Those agencies that reported having no contact with either John or Paul prior to the homicide included:

LBE Adult Social Care (but see para. 2.5, below)

Victim Support

LBE Community Safety Unit

Clinical Commissioning Group

2.5 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

2.6 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.

2.7 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.

2.8 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.

Review Panel Members

2.9 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.

2.10 In addition to the Independent Chair, 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 and Author of the Overview Report

2.11 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.

2.12 As previously mentioned, commissioning of the review was some 14 months after the homicide due to an initial view that the incident had been properly reviewed by the West London Mental Health Trust. The detailed WLMHT review was conducted promptly and available to this DHR. In view of this it was decided that formal Review Panel meetings could be replaced by virtual bilateral meetings supplemented by circulation of the various draft reports as the review developed. The process allowed all contributors to offer their perspectives despite the fact that the borough was faced with conducting multiple DHRs at the same time.

Dissemination

2.13 Once approved by Home Office, the Executive Summary and Overview Report will be published online on the Council's website:

2.14 They will also be shared with the Commissioner of the MPS and the Mayor's Office for Policing and Crime (MOPAC).

2.15 Members of Ealing's Community Safety Partnership will provide oversight of the implementation of the action plan and review learnings resulting from this review.

3. Case History (The Facts)

3.1 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

3.2 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.

3.3 The focus period for this review is from 2015 to July 2020 (the date of the homicide). This period has been chosen because it 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. These relapses were often caused by non-concordance with his medication.

3.4 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

[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.

discharge procedure. Following a period of stability with Paul remaining concordant with his medication, he was discharged from his CTO.

3.5 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.

3.6 Paul 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.

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

3.8 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 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.

3.9 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 via the MOSAIC system.

3.10 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.**

3.11 There are no WLMHT records covering the weekend following the above incident, however on the Sunday evening (19th July), Paul's mother again called 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. *Several 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.*

3.12 The following Monday Police received several calls as a result of which they forced an entry to a flat in Elfwine Road, 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.

3.13 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 left the hospital.

3.14 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 him 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.

3.15 After arrival at the police station, Paul examined by two suitably qualified psychiatrists (under sec.12 MHA) and an Approved Mental Health Practitioner. The experts concluded that Paul showed no signs of acute mental health relapse, 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.

3.16 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 MHA (i.e., that he be detained in a secure mental health facility)

Emerging Themes

3.17 The case history indicates several 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

Diversity and Equality

3.18 John and Paul were both Black British men. Black Caribbean adults were the most likely to use mental health and learning disability services out of all ethnic groups where the data was reliable. (England, 2014/15). Black Caribbean people also had

the highest rate of detention under the Mental Health Act (England, 2017/18)[2]. Despite this obvious disproportionality, no evidence has been found of racial bias affecting the provision of mental health services. There is ample evidence of the disproportionally robust treatment by police of Black British men - especially those suffering from mental illness. In Paul's case however, whilst on some occasions (notably in June 2015) he was taken into custody, when similar circumstances arose in in July 2020, the officers felt so constrained by the provisions of the Mental Health Act that they were unable to arrest him.

3.19 There is no information available to the panel to indicate age; religion or belief; sexual orientation; gender reassignment; marriage/civil partnership; pregnancy/maternity; sex or disability were issues in this review.

4. Overview

4.1 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 on 20th July 2020, 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.

4.2 The assessment made in July 2020 contrasts with the conclusion at Paul's trial 11 months later, made based on 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. The apparent conflict between the assessment made in July 2020 and that made for the trial in 2021 is presumably the result of the assessments being made against differing criteria and to differing standards of proof. This apparent conflict highlights the difficulty of (non-expert) police and ambulance staff when required to determine grounds for detention under section 136 MHA

[2] Source: Office of National Statistics

4.3 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.

5. Analysis

5.1 Paul's history of mental illness extended over many years and whilst there is evidence of several relapses and consequent periods of admission to hospital, there were also lengthy periods in which his symptoms appear to have been managed. The WLMHT identified several problems with Paul's care and management in the period immediately before the tragedy:

- Paul was not followed up by the Duty Team as planned when his family raised concerns in mid-July (see para 3.9). 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 plans 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 at the time living in Paul's house. 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)

5.2 The WLMHT identified the overall ineffectiveness of the crisis plan, even though each agency followed its own procedures. Police Officers are granted powers under section 136 of the Mental Health Act 1983. Where a person appears to be suffering from a mental disorder and to need 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.

5.3 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 powers of persuasion and judgement. 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).

6. Lessons to be Learnt

6.1 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

6.2 **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).

6.3 **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).

6.4 **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).

6.5 **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).

7. Conclusions and Recommendations

7.1 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.

7.2 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.

7.3 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.

7.4 **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 assessment 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.

Appendix A: Action Plan

Recommendation	Actions	Lead Dept	Milestones	Projected completion
Recommendation 1 WLNHT to implement a homogenous approach across teams in CARMHS to managing emergent tasks via local duty with a clear, standardised system to avoid potential confusion	Duty tasks within the MINT services are now supported via the MINT Operational policy which is in place across the 9 MINT teams. This includes clear guidance on core responsibilities, interfaces and administrative tasks with clear lines of accountability	MINT SMT	SOP fully implemented, revisions and monitoring via the Clinical Improvement Group.	Action complete
Recommendation 2 The Ealing partnership 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).	Northwest London Integrated Care Board (NWL ICB) will convene and lead a working group of partners to review existing service development plans to review on-site access to current clinical (including mental health care) records and information sharing protocols creating an action plan to improve collaboration across Ealing of time critical crisis.	NWL ICB	Production of a review report to the Partnership Board	Action complete
Recommendation 3 WLNHT to ensure that recovery teams offer support for all families and carers of clients with psychosis, as recommended by NICE guidance	Support for establishment of local carers groups along with attendance at Ealing Carers strategy group. Psychoeducation offered to families and carers through the recovery college. Carers Assessments are provided by social care colleagues	MINT SMT	Full implementation of existing actions.	Action complete

	with appropriate signposting. The local authority funded Carers Support Worker role has been reviewed and recruitment undertaken. Relaunch of CARMHS Triangle of Care Group with additional actions undertaken: • Information sharing with carers - Practice guidelines developed. • Specification for Residential based Crisis Recovery House from Oct 2022 – Sept 2027 • Carers Rights Day – November 2022 • Identification of Link Workers/Champions per service area • Training in place which is booked via L&D (half day course) • Audit undertaken - Carers perspective on supporting and involving carers in an early intervention for psychosis service Trust wide briefing paper - Carers experience meeting			
Recommendation 4 WLNHT to develop an ERTE system to ensure individual clinicians and their	A report is now available via the West London Business Intelligence on risk assessment status. This is used as part of	Care Planning and Outcome	Reports actioned, audits in place.	Action Complete

managers are alerted to any cases where risk assessment are falling out of date and that updates are audited.	supervision to improve performance. Regular audits undertaken in relation to Risk Assessments	Measures Board CARMHS SMT		
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.				TBA by Home Office.

Appendix B: Consolidated Chronology

Date	Source	Information	Comment
2001	West London NHS Trust	PAUL presented to a Community Health Team with anxiety, depression, and auditory hallucinations	
2003	West London NHS Trust	PAUL admitted to Psychiatric Ward – diagnosis Bipolar Affective Disorder	
2004	West London NHS Trust	PAUL admitted to Psychiatric Ward in August and discharged in October back to GP primary care	L had no further contact with secondary care until 2008, when he was referred by GP to secondary care but discharged back to care of GP
May 2005	MPS	PAUL convicted of Threatening Behaviour – 12 months conditional discharge	
March 2007	MPS	PAUL arrested for possession of cannabis & driving w/out insurance or licence. Fined £500	
February 2010	West London NHS Trust	PAUL admitted under sec 2 Mental Health Act following a manic episode. Discharged in May 2010 but case remained open to the Ealing Recovery Team for the next 11 years. Paul did not settle well in the community and in August 2010 he was again detained under sec 2 Mental Health Act after being arrested by Police	From this point onwards L showed a pattern of reasonable engagement with the community team punctuated by periods of deterioration in his mental state which often required further short-term

			admissions to acute care.
2010	MPS	Information from Paul's doctor that he was "sectioned" sometime this year	
Feb. 2010	MPS	PAUL arrested for criminal damage at his mother's house. NFA taken	
March 2010	MPS	PAUL arrested for ABH, pulling a victim's hair. NFA taken	
Aug 2014	MPS	PAUL arrested for drink driving, no licence or insurance. Fined £230 plus £250 costs & disqualified from driving	
Nov 2014	MPS	PAUL arrested for criminal damage to a bus but subsequently NFA	
June 2015	MPS	Police called to Paul's mother's address where PAUL was aggressive and refused to leave. He was eventually arrested under sec. 136 mental Health Act and taken to hospital where he continued to be non-compliant, having to be carried to the hospital ward.	Police MERLIN record created and shared with Ealing Social Services
Dec 2015	MPS	PAUL and his mother had domestic incident whereby he was throwing his possessions out of the windows. Arrangements made for MH Team to attend the following day but did not appear. MERLIN record states he was fit and healthy and has monthly injections for his bipolar illness	MERLIN record shared with Ealing Social Services
Dec 2015	MPS West	PAUL went to mother's house and behaved aggressively toward her. He eventually forced his way into the house, and she called police. PAUL arrested for common	

March 2016	London NHS Trust	assault and had MH assessment after which he was "sectioned" and bailed by Police. He failed to answer bail after discharge from hospital and was circulated wanted. He was subsequently traced but OIC decided arrest not appropriate He subsequently went to police and accepted a police caution. As a result of the incident above, PAUL was referred to MAPPA and discussed but no further action initiated. A referral was made to domestic violence services for PAUL's mother but there was no clear outcome.	
May 2017	MPS West London NHS Trust	PAUL has MH episode – police called due to him walking naked in the street. On seeing police, he ran away and was eventually caught and detained under sec 136 and taken to Ealing Hospital for treatment then to West Middx Hosp for MH. After a period of treatment L was discharged on a Community Treatment Order (CTO) setting out compulsory medical treatment and allowing a mechanism for swift recall to hospital if needed	MERLIN shared with Ealing Social Services
Nov 2018	MPS	PAUL has a MH episode – found in the River Brent refusing to leave. Eventually rescued and taken to hospital with	

	West London NHS Trust	hypothermia. He subsequently absconded from the hospital but was persuaded to return by JOHN. Assessed by MH Team. PAUL recalled on his CTO due to his relapse and discharged in Jan 2019. The CTO was reset within the discharge procedure.	After his discharge there followed a period of stability. PAUL was concordant with his medication and agreed to engage with his care plan.
Jan 2020 Jan 2020 Jan 2020 Feb 2020	West London NHS Trust	PAUL attended for his depot injection. He appeared "guarded" but concordant with his depot appointment. CPA Review conducted by PAUL's regular consultant. PAUL presented well and was positive for the year ahead. He was well kempt, engaged in an education course and staying with his mother. He agreed to continue with his medication. PAUL attended on time for his regular depot injections. No issues or concerns PAUL arrived late for his depot injection but no issues or concerns.	**Jan – July 2020** PAUL attended the depot clinic for medication. He had been seen as an outpatient 3 times since Sept 2019 and it was planned to see him every 3 to 4 months thereafter. PAUL's diagnosis had remained unchanged for a decade: Bipolar Affective Disorder (then in remission) and mental

		Arrangements for depot injection disrupted by COVID issues but he attended as requested the following day. He appeared unkempt but not to a level of concern.	behavioural disorders due to use of cannabis.
March 2020		Outpatient appointment conducted regular consultant by phone. PAUL appeared well and settled and coping with COVID restrictions. PAUL was aware of how to contact support services should he need them.	
April 2020		Ealing East Recovery Team attempted to contact PAUL as part of initiative to check on service users (re COVID). Paul did not respond to three attempts.	
April 2020		PAUL attended clinic for his depot injection. No evidence of mood disturbance or psychotic features	
April2 020		Ealing Recovery Team contacted PAUL to check his wellbeing. He reported things were going well but asked not to be contacted again this way. He said he would keep his appointments but did not like speaking to people he did not know.	
May 2020		Paul attended for depot injection. No issues or concerns	
June 2020		Duty worker for ERTE received call from PAUL's mother who reported he had been	

July 2020 (Friday) 16.41hrs 17.09hrs		shouting and throwing things in the bin. She requested urgent consideration of a depot injection – this was a Friday, and the next depot was already scheduled for the following Wednesday. The depot was brought forward plus an additional outpatient appointment for the same time. Mother was advised to relay all this information to LAS and Police for urgent response. LAS attended. A second Duty Worker for ERTE received a call from LAS who were on scene. LAS staff reported that there appeared to have been a breakdown in the relationship between mother and son, but that Paul appeared to have capacity. The LAS reported that police would be called if required. LAS staff advised to call the Trust SPA if police required. It was agreed that ERTE would follow up with PAUL on Monday 20th July. Paul has MH episode at his mother's home, throwing things around Police attended but no offences disclosed. Incident properly recorded, MERLIN noted and shared with Ealing Social Services.	
July 2020 (Sunday)	MPS	Paul's mother called police because he was shouting and throwing things, and she was scared. PAUL eventually gathered his things and left. Mother declined DV referral.	

		CRIS and MERLIN records created and shared with Ealing Social Services	
July 2020 (Monday)	MPS	17.52 – neighbour called police saying his neighbour opposite had put knives through the letterbox and spat at his door 18.02 - Neighbour calls again saying he can hear shouting from the address 18.09 – Police attend and after forcing the door find victim in front room with severe head injuries and abdominal stab wound. 18.40 – Life pronounced extinct 19.07 – Call to LAS re a male unconscious in Glade Lane, Southall 19.29 – Male found unconscious and taken to Ealing Hosp., identified as PAUL. He is verbally aggressive. 21.20 – PAUL leaves hospital still in hospital gown 21.44 – Police called to PAUL who is running in and out of traffic, assaulted three people eventually making his way onto the roof of the Fire Station from which he is eventually rescued	
July 2020	MPS	PAUL examined by two Approved Psychiatrists and an Approved Mental Health Practitioner. They concluded that he showed no signs of acute mental health relapse and was fit to be interviewed.	
June 2021	MPS	PAUL pleaded guilty and was convicted of manslaughter of G due to diminished	

		responsibility. Sentenced to a Hospital Order and Restriction Order under the Mental Health Act 1983	

Appendix C – Home Office Quality Assurance Letter

Home Office

Interpersonal Abuse Unit
2 Marsham Street
London
SW1P 4DF

Tel: 020 7035 4848
www.homeoffice.gov.uk

Nazia Matin
Community Resilience Manager
Perceval House
14/16 Uxbridge Road
Ealing
W5 2HL

26th February 2025

Dear Nazia,

Thank you for resubmitting the report (John) for Ealing Community Safety Partnership to the Home Office Quality Assurance (QA) Panel. The report was reassessed in February 2025.

The QA Panel noted that this was clearly a complex review which had been undertaken with sensitivity. The report showed good practice in offering sympathy to friends and family and the Panel noted the detailed account of the interaction the perpetrator had had with local mental health services.

The QA Panel noted that most of the issues raised in the previous feedback letter have now been addressed.

The Home Office agrees that the report can now be published.

Once completed the Home Office would be grateful if you could provide us with a digital copy of the revised final version of the report with all finalised attachments and appendices and the weblink to the site where the report will be published. Please ensure this letter is published alongside the report.

Please send the digital copy and weblink to DHREnquiries@homeoffice.gov.uk. This is for our own records for future analysis to go towards highlighting best practice and to inform public policy.

The DHR report including the executive summary and action plan should be converted to a PDF document and be smaller than 20 MB in size; this final Home Office QA Panel feedback letter should be attached to the end of the report as an annex; and the DHR Action Plan should be added to the report as an annex. This should include all implementation updates and note that the action plan is a live document and subject to change as outcomes are delivered.

Please also send a digital copy to the Domestic Abuse Commissioner at DHR@domesticabusecommissioner.independent.gov.uk

On behalf of the QA Panel, I would like to thank you, the report chair and author, and other colleagues for the considerable work that you have put into this review.

Yours sincerely,

Home Office DHR Quality Assurance Panel

Appendix D – Glossary of Abbreviations

ASC	(Ealing) Adult Social Care
CMHT	Community Mental Health Team
CSU	(Ealing) Community safety Unit
CTO	Community Treatment Order
DASH	Domestic Abuse Stalking & Honour based violence risk
ECSP	Ealing Community Safety Partnership
ERTE	Ealing Recovery Team East
IMR	Individual Management Report
LAS	London Ambulance Service
LBE	London Borough of Ealing
MAPPA	Multi Agency Public Protection Arrangements
MERLIN	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.
MINT	Mental Health Integrated Network Teams
MOPAC	Mayor's Office for Policing & Crime
MPS	Metropolitan Police
NICE	National Institute for Clinical Excellence
NWL ICB	Northwest London Integrated Care Board
WLMHT	West London Mental Health Trust