SaferWalsall Partnership
working together for a safer borough

# Domestic Homicide Review

## Executive Summary

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

**In respect of the death of Francis (August 2019)**

**DHR 9**

**Report produced by Simon Hill**
**(Independent Chair & Author)**

**June 2021**

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# 1 The Review Process

1. This summary outlines the process undertaken by Walsall Community Safety Partnership Domestic Homicide Review (DHR) review panel in reviewing the homicide of Francis who was resident in their area.

2. The family chose the following pseudonyms to provide anonymity:

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

3. 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. 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.

5. 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.

# 2 Contributors to the Review

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

(The IMR authors were independent and were not involved on behalf of their agency in any capacity, with any of the events or decisions described in this DHR.)

# 3 The Review Panel

| Name | Role | Organisation/agency |
|---|---|---|
| Simon Hill | Independent Chair and Overview report writer | - |
| Susan Dicks<br>(Ian Billham from June 2020) | Interim Head of Community Safety | Walsall Council, Safer Walsall Partnership |
| Richard Bridgeman<br>(Vinny Parsons from June 2020) | Not known<br>Detective Sergeant | West Midlands Police |
| Andrew Colson<br><br>(Christine Harris from February 2020) | Quality, Adult Safeguarding Lead<br><br>Interim Designated Nurse Adult Safeguarding | Walsall Clinical Commissioning Group |
| Sharon Latham<br>(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. The DHR panel members were independent of the case, and none had had any involvement with any of the parties subject to the DHR.
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).

# 4 The Author of the Overview Report

1. The DHR Chair/Overview author Simon Hill is a retired West Midlands Police officer, who served on the Public Protection Unit, investigating both child and adult protection cases. He did not work in Walsall and was not involved in any of the events described in the DHR. He has conducted numerous DHRS and SARs around the West Midlands region in the last eight years.

# 5 Terms of Reference of the Review

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

   a) 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?
   b) 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.
   c) 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?
   d) 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?
   e) If the victim had disclosed to any practitioners or professionals and, if so, whether the response was appropriate.
   f) Whether, in relation to the victim and perpetrator, an improvement in communication and information sharing in relation to domestic abuse might have led to a different outcome
   g) Whether the work undertaken by services in this case was consistent with each organisation's professional standards and adult and child safeguarding policy and procedures
   h) 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:

- 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
- Whether appropriate services were offered/provided and/or relevant enquiries made in the light of any assessments made
- The quality of the risk assessments undertaken by each agency in respect of the victim and perpetrator.

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

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

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

l) 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.

m) 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?

n) 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.

3. 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.

   a) 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?

   b) 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?

4. 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 that suggest that, in some (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?

5. **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

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?

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?

# 6 Summary Chronology

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.

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. He subsequently died from his injuries.

3. During pre-school and primary Jesse displayed behavioural problems, but he was not diagnosed with ADHD until he was at secondary school (2007- 13 years of age) and from that point, until he took his own life in August 2020, was prescribed Ritalin or other ADHD-related medication.

4. The DHR were told by the family that they felt Francis had undiagnosed ADHD which may account for why he was apparently hostile and unreceptive in relation to any attempts by Hazel to secure support for Jesse's ADHD. Hazel explained that Francis had an alcohol dependency which caused him to be volatile and aggressive with his family. As a child and adolescent Jesse often clashed with his father, whose disciplinary methods were often harsh and bullying.

5. Jesse was referred to Child and Adolescent Mental Health Services (CAMHS) in 2008 and discharged from the service in 2012. The family were unable to identify any significant progress made in relation to Jesse's ADHD. Services that were offered were not age appropriate.

6. The DHR identified that no additional work to support the family was offered, which could have identified the part the family dynamic played in Jesse's presentation. Importantly, an attempt by Jesse's GP to re-refer to CAMHS in 2013 was refused by the service and this effectively meant that was no transition for Jesse when he went into Higher Education.

7. In 2013, Jesse went to university in Lincoln where over the subsequent four years, he completed a degree and started, but later withdrew from, a Master's degree. He registered with the University of Lincoln Health Service (ULHS). Although ULHS were notified promptly by Jesse's Walsall GP of his ADHD, there was no continuity of care in relation to ADHD because Jesse was not in receipt of service in Walsall. In addition, no adult ADHD services existed in Lincolnshire.

8. During his time at university, and whilst residing in Lincoln, Jesse presented at local hospitals on six occasions with injuries that were the result of either fights, apparent accidents but also deliberate self-harm by overdose of ADHD medication or cutting. Some of these presentations were alcohol- related. At the same time, he was being supported by the University Wellbeing service in relation to anxiety and stress and academic performance issues.

9. Although offered reviews in response to these A&E attendances by ULHS, Jesse avoided contact with the service and resisted or refused support that may have addressed ADHD, other than a single review by a psychiatrist February 2017. (Jesse was 22 years of age). Jesse established a pattern of denial and avoidance in relation to ADHD support that continued until his death.

10. It appears that alcohol misuse, which was to be an increasingly significant comorbidity, was becoming entrenched during Jesse's time at university, although he did not acknowledge this to professionals. Health and Wellbeing Services appeared to fail to make links between Jesse's ADHD, mental health concerns, alcohol misuse and self-harm and suicidal ideation. There appeared to be a lack of awareness and professional curiosity that should have prompted identification of Jesse's vulnerabilities.

11. Jesse's volatile domestic relationship with a local woman, Chloe, started in spring 2017 when he was at university, and continued until mid-2018. Police in Lincoln attended 'loud' domestic disputes on two occasions and some of Jesse's self-harm episodes were linked to relationship issues.

12. A domestic episode between Chloe and Jesse in Walsall at New Year 2018 led to Jesse being arrested and a custody mental health assessment by Diversion and Liaison identified self-harm and depression.

13. Jesse had obtained work in Prague, but his self-harming behaviours and alcohol misuse whilst there led to him losing his employment. He then returned to the parental home in Walsall, (and re-registered with his GP), where his parents tried to support Jesse in relation to his self-harm, suicidal ideation, alcohol, and ADHD.

14. In February 2018 Jesse was persuaded to attend A&E by his mother where he was seen by the Mental Health Liaison team in relation to suicidal thoughts. Jesse acknowledged he was a 'chronic alcoholic', that his ADHD led him to instigate fights, that he often cut himself when he was angry, and that he had a history of cocaine use.

15. During this period, Francis discussed his concerns in relation to his son with the GPs on several occasions. This included alleging that Jesse was abusing Ritalin, his ADHD medication.

16. Referred by his GP to Adult Autism and ADHD Services (AAAS), Jesse failed to engage and left the area, moving for some months to Cornwall, where he appeared to attempt to obtain repeat Ritalin prescriptions by claiming they had been lost.

17. Returning home in October 2018 he was re-referred to AAAS. During this period Hazel was increasingly worried about Jesse, who '*lived like a hermit*' neglecting personal hygiene and living in isolation. She was unaware of her right to seek a mental health assessment as a nearest relative.

18. The two assessments that took place at AAAS in June 2019 were based upon a GP referral that was eight months old and therefore did not describe recent history. There was no involvement of any family members (best practice in relation to ADHD support) because Jesse refused family engagement. There was little evidence that AAAS obtained a detailed history of self-harm concerns, or were aware of any of the most recent assessments of Jesse's mental health.

# 7 Key Issues Arising from the Review

## ADHD support from Childhood into Adolescence and Adulthood

- The apparent inadequacy of the support offered Jesse and his family to understand and address the challenge of ADHD throughout his life
- The critical need to work and educate families where a child is diagnosed with ADHD
- The recognition of ADHD as a condition that can persist into adult life and the need to provide appropriate services as well as ensure transition from child to adult services

## Comorbid presentations and ADHD

- Lack of professional awareness that alcohol or drugs misuse and mental health problems are common comorbidities with ADHD
- The association between ADHD and deliberate self-harm and the appropriate responses when these comorbidities are identified

# 8 Conclusions

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.

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.

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.

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.

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.

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.

# 9 Lessons to be Learned

a. All GPs should ensure that patient records comply with the GMC Guidance[1] with regard to the quality and detail required. (The Walsall CCG will address this concern with the practice.
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.
c. 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.
d. 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.
e. Services offered to children and young people with ADHD must be age appropriate and take into account the different needs of children and adolescents.
f. 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.
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.
h. 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.
i. CCGs should ensure GPs and nurses are aware of signs that a patient with ADHD may be abusing methylphenidate medications.
j. 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. 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.

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

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

# 9 Recommendations

**One: 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**.

Two: 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

**Three: 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.)**

Four: The Black Country Healthcare NHS Trust should ensure that practitioners at AAAS are able to access 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.

**Five: 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.**

Six: 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.

**Seven: 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.**

Eight: 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.