Wolverhampton
A Safe City
Operating as Wolverhampton's Local Police & Crime Board

Domestic Homicide Review

Under Section 9 of the Domestic Violence, Crime & Victims Act 2004

Executive Summary

In respect of the death of

Samuel

in July 2021

Report produced by Simon Hill, Independent Chair and Author

On behalf of Safer Wolverhampton Partnership

January 2024 (*Amended following Home Office feedback in December 2024*)

Contents

Safer Wolverhampton Partnership, the Independent Chair, DHR Panel and participating agencies wish to express our sincere condolences to the family and friends of Samuel for their loss.

1.0 The Review Process

This summary outlines the process taken by Safer Wolverhampton Partnership Domestic Homicide Review (DHR) panel in reviewing the homicide of Samuel who was resident in the area.

The following pseudonyms have been used in this DHR for the victim, perpetrator and other parties as appropriate to protect their identities and those of their families:

Subjects of the Review	**Chosen Anonymisation**
The victim/ perpetrator's father was sixty-two at the time of the homicide. He was of black Caribbean ethnicity	Samuel
The perpetrator / victim's son was twenty-one at the time of the homicide and was of white Scottish and black Caribbean ethnicity	Nathan
The perpetrator's mother/ victim's former partner	Jean
All other parties mentioned have also been anonymised.	

Criminal proceedings were completed in May 2023 and Nathan pleaded guilty to the manslaughter of Samuel, unlawful wounding of another man, a racially aggravated public order offence and criminal damage. He was detained under section 37 of the Mental Health Act 1983 subject to section 41 which allows his detention to continue so long as deemed necessary.

NHS England have a responsibility to commission an independent review into homicides carried out by persons who are being treated for mental illness. In discussion with NHS England, Safer Wolverhampton Partnership and the DHR Chair agreed that the Independent Mental Health Review (IMHR) by NHS England would be carried out in parallel with the DHR and that one of the NHS England Independent

Reviewers would join the DHR Panel. The final IMHR report is included as Annex 1 to the DHR Overview Report.

The DHR sought Individual Management Reviews (IMRs) from all agencies that provided child and adolescent or adult mental health support to the perpetrator, and these were shared with the NHS England Review. The DHR panel considered these IMRs and drew conclusions about key learning and missed opportunities and where these fell outside the scope of the NHS England review, they are considered in the Overview Report analysis.

The DHR agreed the final draft of the DHR Overview and considered the NHS England Review in relation to the care and treatment of Nathan. The DHR panel endorsed the IMHR conclusions and recommendations.

2.0 Contributors to the Review

Individual Management Reviews were requested from:

- Black Country Healthcare NHS Foundation Trust (CAMHS and Early Intervention Services -Wolverhampton)
- Birmingham Women's & Children's Hospital NHS Foundation Trust (Forward Thinking Birmingham)
- Birmingham and Solihull Mental Health NHS Foundation Trust
- Wolverhampton Clinical Commissioning Group (CCG) Now NHS Black Country Integrated Care Board (ICB)
- West Midlands Police

Wolverhampton Children's Social Care (WCSC) responded to specific questions from the DHR which are listed in the Terms of Reference.

The authors of agency IMRs were completely independent and not involved in any of their agency's engagements with the subjects of the review.

3.0 The Review Panel Members

The DHR panel members were entirely independent and not involved in any of the decisions taken by their agencies or responsible for the management of events described.

The DHR panel met on five occasions.

Role	Organisation
Chair and Author	Independent
Community Safety Manager	City of Wolverhampton Council - Safer Wolverhampton Partnership
Domestic Violence Specialist	City of Wolverhampton Council – Safer Wolverhampton Partnership
Safeguarding Nurse	Black Country Healthcare NHS Foundation Trust
Designated Doctor	NHS Black Country Integrated Care Board (Wolverhampton)
Independent Nurse	NHS England Independent Mental Health Review
Operational Manager	Birmingham Women's and Children's Hospital NHS Foundation Trust
Detective Sargeant	West Midlands Police Review Team
Named Nurse for Domestic Abuse	Birmingham and Solihull Mental Health NHS Foundation Trust
Head of Service	City of Wolverhampton Council – Adults Services
Team Manager	City of Wolverhampton Council - Children's Services
Support Officers	Safer Wolverhampton Partnership

4.0 Author of the Review Report

The Chair and Independent Reviewer has over the last eleven years conducted numerous DHRs and Safeguarding Adult Reviews across the West Midlands region. He is a retired West Midlands Police officer who worked within the Public Protection

Unit (PPU) and the West Midlands Police Review Team. He had no professional involvement with the Wolverhampton area during his police service.

5.0 Terms of Reference

5.1 Key Lines of Enquiry

The Home Office has indicated that a DHR should be undertaken. As such the Review Panel (and by extension, IMR authors) will consider what lessons are to be learned about the way in which local professionals and organisations work individually and together to safeguard and support victims of domestic violence, with reference to:

a. Communication between services

b. Information-sharing between services with regard to domestic violence

c. Community understanding of domestic abuse, awareness of how to identify domestic abuse, and routes for reporting domestic abuse: could more have been done to inform local BME communities about services available to victims of domestic violence?

d. Whether family or friends of either the victim or the perpetrator were aware of any abusive behaviour prior to the homicide from the alleged perpetrator towards the victim.

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

a. Professional standards

b. Domestic violence policy, procedures and protocols

c. Safeguarding adult's policy, procedures and protocols

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

a. Whether there were any barriers experienced by the victim or his family/ friends/ in reporting any abuse including whether the victim knew how to report domestic abuse should he have wanted to.

b. Whether there were any warning signs and whether opportunities for triggered or routine enquiry relating to domestic abuse and therefore early identification of domestic abuse were missed.

c. Identification of the key opportunities for assessment, decision-making and effective intervention from the point of any first contact onwards

d. Whether any actions taken were in accordance with assessments and decisions made and whether those interventions were timely and effective

e. Whether appropriate services were offered/provided and/or relevant enquiries made in the light of any assessments made

f. The quality of the risk assessments undertaken by each agency

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

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

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.

5.2 Key Lines of Enquiry - Additional Questions

5.2.1 Questions to be addressed by all agencies

In 2015, incidents occurred between Samuel and Nathan involving disputes and alleged assaults, which lead to Nathan becoming a child in care. Thereafter, Nathan apparently no longer lived with his father. It is unclear how much contact Nathan had with Samuel, particularly in the 12 months preceding the homicide. What (if anything) did your agency know about their ongoing relationship and the frequency of contact between them?

5.2.2 Questions to be addressed by West Birmingham and Black Country CCG (Now NHS Black Country Integrated Care Board)

- Were Samuel's GPs aware of Nathan and in what context?

- Did Samuel indicate he may be supporting/caring for Nathan in relation to his mental health?
- Describe how Nathan's Wolverhampton GPs attempted to obtain mental health support for him when he appeared to be in crisis in May 2021. (Identify whether the apparent difficulty was caused because Nathan was in another Local Authority area.)
- What is the most appropriate pathway to urgent mental health support when an adult appears to a health professional (such as a GP) to be in crisis and potentially at serious risk of harm to himself or others?

5.2.3 Questions to be addressed by West Midlands Police

Nathan was remanded in custody on 07 December 2020, following an incident in which he stabbed another resident of his hostel in the neck. He was charged with malicious wounding section 20 Offences Against the Person Act, racially aggravated public order offences and criminal damage. He was apparently released on 15 January 2021.

- Identify the grounds on which Nathan was granted bail. Was bail opposed?
- Does the decision to grant bail appear appropriate given the circumstances known at the time? What were the terms of bail and were these supervised appropriately?
- In 2020 and 2021, West Midlands Police (WMP) had occasion to use powers under the Mental Health Act (section 136) to take Nathan to a place of safety. Identify whether these applications of section 136 were appropriate. Summarise WMP policy in relation to section 136 as it was at the time.
- Have any changes been made (or proposed), to that policy?

Following one such incident on 29 July 2020, where Nathan was taken into Heartlands Hospital, having been found wandering in a park with a rope with the apparent intention of hanging himself, Nathan was not detained and was not offered any mental health follow up.

- Were WMP aware of this decision?
- What safeguarding measures (if any) were taken in response to this decision?

- What safeguarding response would WMP expect from officers, where a section 136 decision does not lead to the use of section 2 of the Mental Health Act? Were these expectations met following this or any other relevant incident?

5.2.4 Question to be addressed by West Midlands Police, Birmingham and Solihull Mental Health NHS Foundation Trust and Black Country Healthcare NHS Foundation Trust

Describe the remit of and your agency's participation in the Street Triage Scheme at the time under review and whether Street triage were involved in this case? (Identify any changes to Street Triage deployment in Wolverhampton or Birmingham that would impact on agencies ability to respond to adults experiencing mental health crisis)

5.2.5 Questions to be addressed by Birmingham and Solihull Mental Health NHS Foundation Trust, Black Country Healthcare NHS Foundation Trust

- There is evidence that Nathan may have experienced Adverse Childhood Experiences and trauma in childhood and adolescence. Was your agency aware of any such history and is there evidence that practice in this case was trauma-informed?
- Describe and comment on Nathan's transition from child and adolescent mental health services to adult mental health services. Was the transition in line with best practice existing at the time?
- Does an appropriate transition rely upon a young person being in receipt of mental health support at the point they become an adult?
- In relation to the mental health support and assessments of Nathan, identify whether mental health professionals demonstrated an understanding of relevant history? Comment on any apparent gaps in professionals' understanding.
- Were these caused by difficulties in obtaining relevant antecedent history from other sources?
- To what extent were assessments informed by awareness of Nathan's mental health history as a child or young person?
- How could any identified weaknesses in obtaining relevant history be addressed?

Nathan did not have any formal mental health diagnosis before the homicide, although there was a working diagnosis from 2016 of possible dissocial personality disorder. (There is some evidence of cannabis use and Nathan claimed extensive cocaine use in the period under review.)

- To what extent would these co-morbidities suggest a risk of harm to himself and/or others.
- Comment on all opportunities in this case to assess Nathan's suicidal ideation/self-harm in the context of risk to self and others. Were assessments appropriate? Summarise briefly the risk assessment tools used at the time. (Identify in your response any changes that have occurred or are proposed to assessment tools.)
- Is there evidence the risk assessments undertaken by Forward Thinking Birmingham (FTB) took into consideration offending behaviour? (Nathan was on bail for wounding at the time of his engagement with FTB.)
- What is the most appropriate pathway to urgent mental health support when an adult appears to a health professional (such as a GP) to be in crisis and potentially at serious risk of harm to himself or others?

5.2.6 Questions to be addressed by Wolverhampton Children's Social Care

Nathan came to Wolverhampton because of what the WCSC helpful report considered were '*existing social, emotional and behavioural difficulties'.* The DHR has now identified the need to explore this period in greater detail than had first been thought necessary.

It is evident that many of the behaviours and needs Nathan exhibited in adult life, can be traced back to this pivotal period when Nathan moved to Wolverhampton.

The WMP IMR described an incident of conflict between Nathan (aged 15) and Samuel on 25 October 2014 concerning non-attendance at school. Police noted Nathan was 'open' to WCSC. A further physical confrontation also occurred on 10 April 2015 between Nathan (aged 16) and Samuel, that led to him being placed with extended family (uncle and aunts.)

Please provide a detailed summary of WCSC engagement with Nathan concentrating upon:

- Children's Services involvement in these incidents.
- Nathan's experience of trauma in childhood and the known history from Scottish agencies. To what extent is there evidence that Child Protection decisions and support in Wolverhampton were fully informed by an understanding of Nathan's history?
- Describe Nathan's identified needs and vulnerabilities and how these were addressed?
- Examine and describe the level of co-operation from those with parental responsibility /and or the extended family. Was there any evidence of parental neglect?
- What was the legal position concerning Nathan between April 2015 and July 2016 (Nathan was 16/17 years) if Nathan was only identified as 'in care' after July 2016?
- Is there any evidence that the Local Authority did not meet any of its' statutory duties under the Care Act in relation to Nathan?
- Describe the Local Authority's legal duties to accommodate a young person under 18, at risk of homelessness. Did the Local Authority meet those duties? (Identify all known addresses and the level of professional support Nathan received if premises were 'supported' accommodation (February 2016).
- Describe the period Nathan was a child in care; July – August 2016. Identify any agency supporting Nathan and the nature of that support.
- Nathan was 18 in December 2016. Describe any duty that fell to the Local Authority to support Nathan beyond 18. Was this met? Describe any transition to Adult Services initiated by WCSC.
- Critically evaluate the information provided and identify any relevant learning.

6.0 Summary Chronology

Samuel was described in Police statements as a '*humble man'* who enjoyed routines; he would visit a local market four times a week and enjoyed listening to music and would have a drink at a local social club on Friday and Saturday evenings. Samuel

suffered significant health problems; he had experienced heart attacks and strokes and had had a 'pacemaker' fitted in early 2020.

Samuel had started a relationship with Jean, the perpetrator's mother, around twenty-five years ago, when she worked as carer to an elderly neighbour. A year later, Nathan was born; it was, according to Jean, an unplanned pregnancy. Jean had children from a previous relationship, with whom apparently Samuel formed a '*good'* relationship but when in 2000, Samuel discovered Jean had allegedly had an affair she and the children moved back to Scotland when Nathan was around two years old. She apparently changed his name to make it harder for Samuel to discover their address and Nathan had no contact with his father.

Nathan suffered a range of Adverse Childhood Experiences (ACEs) from early on and into adolescence. He experienced parental separation and rejection by both parents. He was allegedly subjected to racial and physical abuse by his family in Scotland, leading to involvement in crime, truanting and elicit substance use and mental ill health. His violence towards his mother led to him being taken into care at 14.

In 2014, Nathan (15) moved back to Wolverhampton to live with his father, because his mother could not control him. By October 2014, Nathan (15) was in contact with WCSC claiming to be homeless and depressed because he was living with his father who was unwilling or unable to provide material things Nathan wanted, and this led to conflict. After a brief involvement with WCSC and a failed attempt to find Nathan suitable accommodation with family in the area, by November 2014, Samuel had paid for a return ticket to East Lothian for Nathan (15), where local social services acknowledged his return.

However, by February 2015, Nathan (16) was back in Wolverhampton, claiming to be homeless. Samuel made it clear in Nathan's presence, that he did not want him moving in with him, even for a short period. However, reluctantly, Samuel relented, and Nathan moved back to Samuel's home. Nathan was attending college and skills-based training as well as mediation. Between February 2015 and July 2015, Nathan was supported under a Child in Need Plan (CIN section 17 Children's Act 1983)[1]

[1] Under Section 17 Children Act 1989, a child will be considered in need if:

- They are unlikely to achieve or maintain or to have the opportunity to achieve or maintain a reasonable standard of health or development without provision of services from the Local Authority.

In April 2015, Police were called by Nathan (16) to a renewed conflict between him and Samuel, which seemed to be a clash over Nathan refusing to abide by his father's rules or standards, and an argument over money. Samuel had allegedly grabbed Nathan by the neck and arm, pushing him against the wall, bumping his head. Nathan had responded by wrestling his father to the floor. Samuel was clear that Nathan could no longer stay with him, and in any case the police were investigating an allegation of wilful assault of a child under 18, so from a child protection point of view, Nathan's continued residence with his father was not deemed safe.

For the next six years, Samuel lived on his own. He had become estranged from his son, and there apparently was little or no contact between them.

2016 represents a period in the chronology where Nathan (17) was increasingly involved in criminal activity, that included offences of violence, sometimes whilst under the influence of drugs. The care of Nathan was once again managed through a CIN Plan, that lasted from February to December, when Nathan turned eighteen. The CIN plan identified a lack of familial sources of support.

Professionals noted a significant decline in Nathan's wellbeing and mental health and there was renewed involvement with support services. This included involvement with Child and Adolescent Mental Health Services (CAMHS) from July 2016 (17) to February 2018 (19). He was also referred to substance misuse services in Wolverhampton.

Having described suicidal ideation and low mood, Nathan was referred to CAMHS by the Youth Offending Team (YOT) in 2016 where the presence of psychosis was explored. Early on Nathan spoke of a conviction that he had had a '*metal implant'* into his body that affected mood, behaviour, and decisions and in Nathan's mind '*controlled him'*. He was assessed by a Consultant in Child and Adolescent Mental Health. The referral from YOT had suggested that Nathan had been talking about '*evil spirits'* and was feeling that '*something wanted to kill him*' and that he wanted to '*hurt others'* but that he also did not want to live like this anymore. His YOT support worker had referred Nathan to CAMHS as he felt concerned that '*Nathan may kill himself, kill someone else or commit a crime.*'

- Their health or development is likely to be significantly impaired, or further impaired, without the provision of services from the Local Authority.

Substance misuse was a factor in Nathan's offending behaviours. He told CAMHS he used cannabis, mamba[2] and cocaine, and although he initially would not recognise this, it does appear the frequency with which he reported hearing voices corresponded to increased cannabis use, suggesting possible cannabis induced psychosis.

Providing Nathan with suitable accommodation was very challenging. Throughout this period, Nathan's drug misuse and aggression led him to clash with other residents and staff and damage property which caused him to be removed from accommodation. In the period between February 2015 and his eighteenth birthday, Nathan lived at sixteen separate addresses. He became increasingly involved in offending, including assault with intent to rob, leading to a short period spent in a Young Offenders Institute and once more was a child in care. Between 2018 to 2020, Nathan moved between hostels in Birmingham and Wolverhampton and also to Scotland, but his violent and antisocial behaviour led often to him being asked to vacate accommodation.

2020 saw Nathan accused of an assault on a fellow hostel resident and increasingly expressing suicidal ideation with calls to the police disclosing an intention to kill himself which lead to Nathan being taken to a place of safety under section 136 of the Mental Health Act 1983[3]. He was assessed as '*not having any serious mental health issues.'*

In early December 2020, a resident of a hostel called Police and alleged he had been stabbed in the neck by Nathan, who had only moved in two days prior. Nathan was found in his room and was intoxicated, with slurred speech and he was unsteady on his feet. The knife was recovered, and he was arrested. On the way into the police station, Nathan engaged in racially abusive attacks on the arresting officer, as well as repeatedly spitting in the vehicle. Once in custody, he threatened to stab the officer. (These offences were charged and subsequently dealt with during Nathan's trial for murder).

Although bailed by the court to a fixed address, Nathan soon found reasons to move address repeatedly, without permission, and although he encountered police on several occasions in the following months, they failed to identify him as being in breach of bail.

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[2] Mamba or black mamba is a form of synthetic cannabis considered a 'legal high' until it was banned under the Misuse of Drugs Act in 2012. It is believed to cause paranoia in some users.

[3] Section 136 is an emergency power to remove a person at serious risk of harm to self to a place of safety which is usually a hospital or specialist unit for up to 72 hours to allow assessment and the arrangement of detention for treatment under the Mental Health Act 1983.

In May 2020, during his first contact with his Wolverhampton GP in 2 years he claimed he was hearing voices telling him to '*kill people'*. He said (inaccurately) that he was on bail for attempted murder. The GP made an urgent and important referral to Birmingham Community Mental Health services; Forward Thinking Birmingham (FTB) on this basis, sharing all of Nathan's claims. At the end of May 2021, a FTB Crisis team nurse contacted Police explaining Nathan had made a call telling them he was about to kill himself. He was located and again detained by police under section 136 of the Mental Health Act 1983 but was not sectioned.

FTB engaged with Nathan from the date of the referral from the Hospital in early May, until mid-June. Nathan's engagement was not wholehearted, and in addition he did not have a Birmingham GP (a prerequisite for the provision of a Birmingham service) so he was discharged back to the care of his Wolverhampton GP.

Nathan had apparently renewed contact with his father since April, but no professional knew this was the case.

On 19 July 2021, Police encountered Nathan on a street in Birmingham. He seemed disorientated and confused and when they identified who he was and became aware of his involvement with FTB, they contacted FTB's Referral Management Centre. It seems likely from forensic evidence gathered by Police, that Nathan had killed his father in the hours preceding this encounter.

After Samuel's friend requested Police conduct a 'safe and well check', Samuel's body was discovered in his home. He had been repeatedly stabbed by Nathan apparently after an argument.

Subsequent psychiatric reports in custody identified Nathan was suffering paranoid schizophrenia.

7.0 Key Issues Arising from the Review

The chronology has described in detail the largely separate paths taken by the victim, Samuel, and his son Nathan. Theirs' is a story of family breakup early in Nathan's life and long periods of enforced separation leading to estrangement. When Nathan came back to Wolverhampton to live with his father as a teenager, after a very troubled adolescence in Scotland, they were in many respects, strangers. Nathan was a young person whose personality and emotional wellbeing had seemingly been affected by

multiple adverse childhood experiences (ACEs). Samuel for his part, had not been called upon to carry out any parenting role for years, so may have lacked some of the necessary skills or support.

7.1 Opportunities to identify Nathan's potential risk to Samuel

If Nathan's trajectory of violence, drugs misuse and mental ill health was a potential consequence of toxic childhood stress, it does not necessarily follow that the potential risk to Samuel from his son could or should have been identified. In adult life and certainly in the two years before the homicide, Nathan consistently spoke to professionals of his lack of family support. He described being estranged from his father. No professional knew of the contact they were having in 2021, in the months immediately preceding the homicide. The DHR, informed by hindsight, has recognised that some of Nathan's assertions made to professionals could not always be relied upon. However, there is no reason that statements about a lack of contact with his father would have been challenged.

7.2 Opportunities to identify risk to self or others in the context of Nathan's Mental Health Support

The DHR and IMHR addressed whether Nathan's presentation, in the months before the homicide, during mental health support around self-harm and suicidal ideation, should have alerted professionals to potential risk not just to himself, but to others and by extension, possibly to Samuel. Here in particular, hindsight bias must be avoided.

FTB, as part of the crisis mental health assessments in May 2021 (two months before the homicide) needed to identify accurately Nathan's risk of harm to himself and others. This assessment should be informed by any antecedent mental health history and accurate assessment of any known relevant offending behaviour. The DHR and IMHR regretted that FTB were unable to obtain the necessary history relating to Nathan's involvement with CAMHS in Wolverhampton. There was no structural or systemic reason this information was not obtained; rather it appeared to be a failure to be adequately persistent in enquiries with CAMHS, due in some measure to COVID-related staffing issues. This weakness was compounded by a failure to make appropriate enquiry of agencies like Police or Probation, who could have provided accurate information on Nathan's offending behaviour.

Their assessment therefore of whether, because of a mental disorder, Nathan posed a risk to others, was reached based in part upon Nathan's false assertion that he was on bail for attempted murder. This apparently informed safety decisions for FTB staff with managers recommending that professionals should not work with Nathan alone. There was no corresponding assessment that he potentially posed a risk to others in the community, when in crisis. This would suggest that FTB's assessment of any risk to others from Nathan's mental ill health, would not have changed, had they known that Nathan faced far less serious charges, albeit still ones that involved violence to others. The need to ensure FTB address these evident vulnerabilities in risk assessment are addressed with single agency recommendations for Birmingham Women's and Children's Hospital NHS Foundation Trust (FTB) in the IMHR.

On two occasions, Police officers used section 136[4] of the Mental Health Act 1983 to remove Nathan to a place of safety. The DHR was satisfied that the threshold for section 136 Mental Health Act 1983, that Nathan was '*in immediate need of care or control'*, had been met and the use of this police power was appropriate on each occasion, given the risk. Neither Review found any basis to question the reliability of subsequent assessments made when Nathan was taken to a place of safety but was not then subject to compulsory detention. The use of 'sectioning' should be restricted to situations where compulsory assessment in a hospital is the only possible way to ensure the safety of the individual, or of others. In this case, crisis community mental health assessment and support, such as was offered by FTB, was the appropriate least restrictive path.

It is quite possible that unknown to professionals, Nathan's mental health had worsened in the weeks after FTB ended their engagement and immediately before the homicide. Nathan's frequent use of drugs may have heightened his levels of aggression, paranoia, and anxiety.

[4] If a person appears to a constable to be suffering from mental disorder and to be in immediate need of care or control, the constable may, if he thinks it necessary to do so in the interests of that person or for the protection of other persons—

(a)remove the person to a place of safety within the meaning of section 135, or

(b)if the person is already at a place of safety within the meaning of that section, keep the person at that place or remove the person to another place of safety.

7.3 Opportunities to reduce risk of harm posed by Nathan through use of police powers

WMP encountered Nathan five times after he was placed on bail, between March 2021 and the last occasion on 19 July 2021, probably in the hours after he had killed his father. Regrettably on none of these occasions did officers identify Nathan was in breach of court bail.

The DHR considered whether a breach of bail would have altered the course of this case and concluded that it would probably not have done so. In the context of the Police encounters with Nathan, an arrest for breach of court bail would have probably led to detention in custody, to be brought before the court the following morning. Had Nathan been represented, it is unlikely that he would have faced remand for a first bail offence. Whilst regrettable, the missed opportunities were not pivotal in preventing Nathan's homicide of his father.

Learning Point: Bail Checks

West Midlands Police should remind officers of the need to carry out appropriate intelligence checks to increase the likelihood that breaches of police or court bail are detected. They should be mindful that a victim of crime with a history of offending could be in breach of bail and should actively consider appropriate checks of that individual.

7.4 Wolverhampton Children's Social Care: Opportunities to reduce risk by effective support of a Child In Need (2014 to 2016)

The DHR acknowledged that WCSCs efforts from 2014 to 2016 to support Nathan, faced very real challenges due to his complex needs. Because he twice returned to Scotland, then came back to Wolverhampton, there was a significant amount of work carried out to support him by both Local Authorities and liaison between social workers appeared mostly effective. It was WCSC that led on putting in place support in relation to mental health (CAMHS), drugs misuse and housing, whilst supporting his education and involving an Intensive Family Support (IFS) worker who encouraged Nathan to develop the skills needed for independent living.

The complex needs of Nathan demanded a structured approach, and under the Children's Act, when he was identified as a Child in Need (CIN) on a CIN plan, that would be usually through CIN Meetings. Regrettably, the WCSC IMR made it clear that

CIN meetings were not often held. WCSC provided assurances to the DHR that in 2022, the monitoring of CIN Plans is subject to auditing to ensure that CIN Meetings occur every four weeks.

Learning Point: The need for CIN meetings or multi-disciplinary meetings for children or young people with complex needs

Children and young people being supported with complex needs require a structured approach and in the context of a child in need (CIN), or a child on a Child Protection plan or a child in care, the Children's Act provides guidance on appropriate reviewing of such plans. Outside of this statutory structure, professionals should identify a Lead professional and hold multi-disciplinary meetings to identify what support a young person with complex needs will engage with, but also identify unmet needs.

8.0 Lessons Learned

8.1 The impact of Adverse Childhood Experiences (ACEs) upon physical and mental wellbeing in childhood, through adolescence into adult life

This DHR was struck by Nathan's very sad life trajectory. Living with half siblings in Scotland, he felt himself to be unloved and unwanted by his own family. He apparently experienced bullying, physical, and racial abuse and name calling both in his home, but also in the community. He felt an outsider, a black child in a predominantly white community. He experienced parental separation at a young age and subsequent parental rejection by both his birth parents.

It seems clear that in childhood and adolescence, Nathan had to contend with the toxic stresses of multiple ACEs that impact upon general wellbeing into adult life. Based on research quoted extensively in the Overview report, it was sadly very predictable that Nathan would develop mental ill health leading to psychosis, suicidal ideation, and substance abuse, because of the experience of multiple ACEs.

The DHR would recommend greater focus on preventing the experience of ACEs through Public Health initiatives to improve child and adult wellbeing and outcomes.

8.2 Trauma-Informed Practice to Build Resilience

In the context of Nathan's childhood and adolescence he experienced what is described as complex or developmental trauma; chronic traumatic events which persist over a longer period; repeated abuse, neglect, separation. This kind of trauma generally occurs in the context of relationships. Nathan's history following the breakdown in his relationship with his father was one characterised by an apparent inability to regulate emotions, leading to violence and aggression and offending behaviours.

The ability of both adult and child services to provide trauma-informed practice is crucial because without it, the chance of resilience and recovery being achieved is greatly reduced. Trauma-informed practice is relevant to all sectors of public service including Child and Adult Social Care, Physical and Mental Health services, Education, Housing and the Criminal Justice System.

There were early opportunities to identify the impact of trauma upon Nathan's offending behaviour, however the contacts he had with Youth Offending Service (YOS) led primarily to CAMHS interventions, that focused more on the nature of Nathan's mental ill-health. The chronology in this case would suggest that Nathan did not benefit from the kind of trauma-informed practice within the Criminal Justice System, which was just beginning to be recognised as vital during that period.

Trauma-informed practice models now exist within YOS and are recognised through inspections of YOTs to be effective, which gives the DHR grounds to believe that a young person meeting YOTs today, would receive an improved and more trauma-informed, holistic level of support.

The DHR has been provided less compelling evidence to suggest that adult services are as advanced in developing trauma-informed practice as for example, YOS. Trauma informed approaches require organisations or services to demonstrate a commitment to responding to the needs of trauma survivors regardless of the services' primary purpose, for example, mental health or substance misuse treatment services.

The NHS Long Term Plan[5] in August 2019 promised, '*a new community-based offer will include access to psychological therapies…personalised and trauma-informed*

[5] NHS Long Term Plan section 3.92

care'. The DHR would propose that Safer Wolverhampton Partnership take the learning from this review, and the recent introduction of a definition of trauma, to prompt an evaluation of how far services in Wolverhampton have gone in meeting the NHS Long Term Plan in relation to trauma-informed practice. The DHR would recommend that commissioners of health and care services in Wolverhampton ensure that they are providing services that are trauma informed.

8.3 Parricide and Identifying Possible Links to Child to Parent Abuse

Parricide, the killing of one's parents, is a neglected area of study in criminology. Early studies tended to be divided into work by psychiatrists who suggested that adolescent parricide was linked to mental ill health caused by parental mistreatment over a prolonged period. The alternative sociological approach focused on family dysfunction.

In analysing the victim and perpetrator's relationship and the associated risks, the DHR was influenced by the work carried out for the Domestic Abuse Commissioner around the ecological model of Child to Parent Violence and Abuse (CAPVA) and Dr. Amanda Holt's[6] descriptions of the changes in the parent /offspring relationship through the lifecycle. Samuel's clashes with an adolescent Nathan were at risk of continuing when he became an adult however the risk associated with fighting back became potentially more serious.

Learning Point: Understanding familial abuse and violence in the context of domestic abuse

Professionals should endeavour to identify episodes of conflict in the lifecycle of a family and contextualise them as part of familial domestic abuse to better identify effective support for both parents and child, but also to identify earlier risk to each member of that family.

Understanding the ecological model of child and adolescent to parent violence and abuse should form part of the training of all professionals supporting families.

[6] Exploring Fatal and Non-Fatal Violence against Parents: Challenging the Orthodoxy of Abused Adolescent Perpetrators. (International Journal of Offender Therapy & Comparative Criminology 2018 Vol 62(4) 915-934

9.0 Conclusions

The impact of ACEs upon Nathan, and the importance of responding to trauma and childhood stress in an early help context, are dramatically illustrated in this case. Services offered to the family during Nathans' adolescence and into adulthood were not providing trauma-informed care, which it must be acknowledged was not common practice in the period described. It is hoped this DHR will add to the already large evidence base to justify a Public Health strategy focused upon early interventions and trauma-informed practice.

10.0 Recommendations

The DHR has been undertaken in parallel with an NHS England IMHR that has made recommendations for Birmingham Women's and Children's Hospital NHS Foundation Trust, who were partners in both Reviews.

The recommendations of the IMHR were endorsed by the DHR and Safer Wolverhampton Partnership. The implementation of the recommendations will be overseen by NHS England and Safer Wolverhampton Partnership will be provided with updates under agreed monitoring arrangements.

Recommendation One: Safer Wolverhampton Partnership to share the key findings of this DHR with Local Authority Public Health, the Office for Health Improvement and Disparities and NHS England to inform the national and regional approach to embedding trauma-informed practice						
Ref	**Action (SMART)**	**Lead Officer**	**Target Date**	**Desired outcome of the action**	**Monitoring Arrangements**	**How will success be measured?**
1.1	Safer Wolverhampton Partnership to identify with Public Health how best to share the learning from this DHR with national and regional agencies developing public health policy and ensure learning is shared appropriately.	Head of Communities (Public Health)	March 2024	That the learning from the death of Samuel informs the approach to embedding trauma informed practice	Safer Wolverhampton Partnership – DHR Standing Panel	Acknowledgment received

Recommendation Two:

Commissioners of health and care services in Wolverhampton provide assurance to Safer Wolverhampton Partnership that trauma-informed care (TIC) forms part of their commissioning framework and that the six principles of trauma informed practice are reflected in services and systems.

Ref	Action (SMART)	Lead Officer	Target date	Desired outcome of the action	Monitoring Arrangements	How will success be measured?
2.1	Safer Wolverhampton Partnership partner agencies in health and care provide a summary of how far their commissioning frameworks have embedded TIC and any strategic plans that are relevant to implementing TIC.	Adult Safeguarding Leads	June 2023	Safer Wolverhampton Partnership have a clearer understanding of the progress towards the NHS England Long Term Plan related to community-based care that is trauma-informed.	Safer Wolverhampton Partnership – DHR Standing Panel	