Wolverhampton
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Domestic Homicide Review
Overview Report

Report in respect of the death of

Samuel

in July 2021

Report produced by Simon Hill, Independent Chair and Author

For 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 Timescales

The Domestic Homicide Review began In October 2021 and was concluded in April 2023.

It was necessary to synchronise both the Domestic Homicide Review (DHR) and the Independent Mental Health Review (IMHR), which was briefly paused to allow a decision upon whether the offender could be interviewed by the IMHR. The delays to the Criminal trial meant that the IMHR was not available to the DHR Chair in draft until October 2022, after NHS England agreed it should be completed without the subject being interviewed. It could not be shared with the full DHR Panel until November 2022 when NHS England completed necessary checks for factual accuracy.

The DHR was submitted to the Home Office after Safer Wolverhampton Partnership and NHS England agreed how recommendations and action plans would be monitored.

2.0 Confidentiality

The findings of a DHR are confidential and information was shared only with participating officers and their line managers. The Overview report was shared with participating agencies through their panel representatives and was also confidential until approval for publication was received.

The victim's family did not feel able to contribute to the DHR, therefore the anonymisation of parties involved was agreed by the DHR panel.

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	Nathan

white Scottish and black Caribbean ethnicity.	
The perpetrator's mother/ victim's former partner	Jean
All other parties mentioned have also been anonymised.	

3.0 Terms of Reference

3.1 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.

3.2 Key Lines of Enquiry - Additional Questions

3.2.1 Questions to be addressed by all agencies

In 2015, incidents occurred between Samuel and Nathan involving disputes and alleged assaults, that lead to Nathan becoming a child in care (CIC). 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?

3.2.2 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?

3.2.3 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?

3.2.4 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 was 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).

3.2.5 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 took into consideration offending behaviour? (Nathan was on bail for wounding at the time of his engagement with Forward Thinking Birmingham.)
- 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?

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

Nathan came to Wolverhampton because of what WCSCs' 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 Independent Management Review 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 the 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.

4.0 Methodology

The Chair of Safer Wolverhampton Partnership requested a summary of each agency's involvement to prepare a scoping document which would inform decisions taken concerning the Terms of Reference.

5.0 Involvement of Family and Friends, Work Colleagues, Neighbours and Wider Community

Safer Wolverhampton Partnership wrote to family and friends to offer them the opportunity to share their views with the DHR. Unfortunately, no family members or friends of the victim felt able to contribute during the period that the homicide was being reviewed.

The DHR panel and IMHR considered engaging with the offender Nathan, however his mental ill health led us to conclude, following advice from the Senior Investigating Officer (SIO) that contact with him may be inappropriate within the timescales of the review.

6.0 Contributors to the Review

Individual Management Reviews (IMR) 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 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.

7.0 The Review Panel Members

The Panel members were all independent of the events described in this DHR and were not involved with any of the decisions taken by their agencies.

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
Safegarding 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 & Children's Hospital NHS Foundation Trust
Detective Sargeant	West Midlands Police
Named Nurse for Domestic Abuse	Birmingham and Solihull Mental Health NHS Foundation Trust
Head of Service	City of Wolverhampton Council Adult Services
Team Manager	City of Wolverhampton Council Children's Services
Support Officers	Safer Wolverhampton Partnership

8.0 Author of the Overview 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 served as an officer with WMP and worked within the Public Protection Unit (PPU)

and the WMP Review Team. He had no professional involvement with the Wolverhampton area during his police service. He retired in 2013.

9.0 Parallel Reviews

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 this DHR.

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.

HM Coroners carried out an inquest into the death of Samuel. His death was recorded as an unlawful killing.

10.0 Equality & Diversity

The DHR considered the nine protected characteristics of the Equality Act 2010 and found none to be relevant to the review.

Samuel accessed support from Wolverhampton Children's Social Care, Health providers and WMP. He was a man of Caribbean ethnicity who was well integrated in his community and until health conditions impacted upon him, was working and socialising within that community.

11.0 Dissemination

The Overview report will be shared with all agencies listed as contributors to the review, the members of Safer Wolverhampton Partnership, the Office of the West Midlands Police and Crime Commissioner, and the Domestic Abuse Commissioner.

12.0 Background Information (the facts)

The Chair of the Overview report and panel members regret that it is has not been possible to obtain a fuller picture of Samuel's life. It had been hoped that family members would engage with the DHR post-trial, or that WMP would be able to share details from witness statements. Although Nathan pleaded guilty to manslaughter on the grounds of diminished responsibility, the delay in sentencing has led the Chair to conclude that oversight of the Overview report by Safer Wolverhampton Partnership should not be delayed any further.

Samuel was the eldest of six siblings; only one brother lived in the West Midlands, the remainder living in London. He 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. Prior to COVID restrictions, Samuel would have a drink at a local social club on Friday and Saturday evenings.

In the period under review, Samuel suffered significant health problems; he had experienced heart attacks and strokes and had had a 'pacemaker' fitted in early 2020.

Samuel had lived alone in recent years. He had been estranged from his son, the perpetrator, Nathan, for six years and there had apparently been little or no contact between them. However, the WMP IMR indicated that the homicide enquiry established Nathan had been in contact with his father from April 2020. It is not clear how frequent this contact was, given the UK was then in the first and strictest COVID lockdown restrictions.[1]

Samuel had a close female friend, Clarissa, who spoke with him by phone several times a day. She had been aware of Samuel and Nathan renewing contact and had apparently been anxious because Samuel had disclosed a history of conflict with his

[1] The first COVID lockdown was from 23 March 2020 to 05 May 2020.

son, although it is unclear whether this was a description of historic or more recent events.

The IMRs presented to the DHR would suggest that although Nathan had contact with health professionals in Emergency Departments and Community Mental Health Teams, as well as Police officers in the six months before the homicide, professionals were unaware that Nathan was in contact with his birth father and therefore no professional had the opportunity to assess the potential risk Nathan posed to Samuel.

In July 2021, Police attended Samuel's home for a 'safe and well' prompted by Clarissa, who had been unable to contact her friend. Entry was forced to the premises, where Samuel was found deceased. He had suffered multiple stab wounds. Nathan was arrested on suspicion of murder some days later and was subsequently detained in hospital under section 48/49[2] of the Mental Health Act 1983.

In November 2021, Nathan was charged with murder. In November 2022, Nathan pleaded guilty to manslaughter on the grounds of diminished responsibility and the matter adjourned for sentencing. 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.

13.0 Chronology

{Relevant ages for Nathan will be annotated in the Chronology after incidents described (age)}

Samuel had started a relationship with Jean, the perpetrator Nathan's mother, around twenty-five years ago, when she worked as carer to an elderly neighbour. She had children from a previous relationship, with whom apparently Samuel formed a '*good'* relationship. A year later Nathan was born; it was, according to Jean, an unplanned pregnancy.

When Samuel discovered Jean had allegedly had an affair, she moved back to Scotland in 2000, taking Nathan with her; he was around two years old. She apparently

[2] Section 48/49 Mental Health Act 1983 allows a person remanded in custody in prison to be moved to hospital. Section 49 is a restriction direction where the person is considered a risk to the public.

changed his name to make it harder for Samuel to discover their address and quite soon Nathan had no contact with his father. Nathan often described his life in Scotland as unhappy when as an adolescent, he met with health professionals. In early childhood, he had idealised his absent birth father, who offered in his mind, an alternative to his life in Scotland.

He was the only black child in a white family with four half siblings, all, Nathan alleged, with different fathers. He claimed his relationship with them was not always good and that he was subject to racial abuse within the local community, but also from his own family.

In his mental health assessment, upon his arrest for the homicide of his father, Nathan claimed that at five, his mother started a new relationship and by seven, he was suffering physical abuse at the hands of mother and her partner. He also alleged making a report of intrafamilial sexual abuse by a family member. This was not corroborated in any IMRs and unfortunately many of the local records of any Social Service involvement with the family are lost or have been weeded.

Jean stated in her police evidence that when Nathan was nine, she had another child, and he did not respond well to this. He was allegedly jealous, and his behaviour deteriorated, including going missing. By 12, Nathan's school attendance was reportedly poor and there would be arguments over this. Nathan was allegedly stealing from the family, and he was apparently often in conflict with his mother. At the same time an older female sibling was abusing drugs, and this caused family tension when she also allegedly stole from them. According to Nathan's mother, the Police were frequently in attendance.

Jean describes a degree of child to parent abuse and violence; Nathan would pin her to a chair and '*get in her face*' during arguments and she described fearing her son.

The DHR was made aware of a period during his time in Scotland, when at around 14, Nathan was taken into care for around seven months. According to records held by Wolverhampton Children's Social Care (WCSC), this was secure accommodation. There is no reliable information on why the authorities resorted to such a robust measure. The only available notes suggest that during an assessment by WCSC in 2014, a Scottish social worker familiar with the case noted it was not because of causing personal injury to any person and was excessively restrictive.

In 2014, Nathan (15) moved back to Wolverhampton to live with his father, because his mother could not control him. It is unclear how much contact Nathan had had with his father in the years since he moved to Scotland, but it seems safe to assume based on Jean's earlier view on contact between father and son, that there had been very little or none.

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. WCSC appointed a Parenting Support Advisor, but at the end of the month Samuel called Police to warn them he anticipated problems with Nathan. They had argued and Samuel claimed his son was trying to provoke a reaction from his father; he had thrown a plate of food over the floor.

Samuel was clear he could not have his son living with him and family members (described variously as cousins or aunts), agreed to Nathan living with them. They reported to WCSC that Nathan had expressed suicidal ideation. WCSC suggested counselling for Nathan, but by November 2014, Samuel had paid for a return ticket to East Lothian for Nathan (15), where local social services acknowledged his return.

Nathan met and communicated with a young man, Steve Mason, a quadriplegic, through the online gaming community. It is unclear exactly when they first met online, but it seems this friendship was a reason Nathan gave to professionals for returning to Wolverhampton. Steve Mason was later able to provide Police with insights into Nathan's perceptions of his father and himself. He featured obliquely in later incidents which suggests he was a significant adult in Nathan's life, but one not properly identified and acknowledged by professionals. CAMHS knew of him, indeed he was identified as posing a risk of exploitation to Nathan; he was also recorded by CAMHS as having supplied him with 'cannabis cake'. There is no evidence that this risk was followed up after Nathan consistently denied this was the case.

By February 2015, Nathan (16) was back in Wolverhampton, claiming to be homeless. Accommodated in a YMCA, within two weeks he was asked to leave, for having been verbally aggressive with staff and making '*inappropriate comments'* to other residents. This was one of several incidents in Nathan's history where he appeared to have low frustration tolerance and a disregard for the feelings of others.

Nathan was told by WCSC to go home to Scotland, but he said he was '*fearful he would fall in with the wrong crowd*'. 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)[3]. WCSC noted only one CIN meeting took place; demonstrating a significant lack of robust supervision of Nathan's support at that time.

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 claimed Nathan had been '*disrespectful and aggressive'* and had thrown his food on the floor. Samuel claimed to be fearful for his safety and had acted he felt, reasonably, to prevent harm to himself or damage to his property. 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.

Nathan later corroborated his father's account and refused to be medically examined or give a child video evidence interview. His father was voluntarily interviewed and denied assault, and in the absence of sufficient evidence to meet a prosecution threshold, the case was closed with 'no further action.'

Nathan consequently lived briefly with an uncle, but then in May 2015 an aunt, agreed to have him live with her. Unfortunately, by July the relationship deteriorated because Nathan (16) would not '*live by her rules.*'

By July 2015, Nathan (16) was eligible for housing support in Wolverhampton and moved into the YMCA again, but was asked to leave in February 2016, for smoking

[3]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.
- Their health or development is likely to be significantly impaired, or further impaired, without the provision of services from the Local Authority.

cannabis and having arrears. He (17) was then accommodated by the Local Authority in a hostel, but after an incident in March 2016, which led to his arrest, he was asked to leave.

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. The extended family, who had helped Nathan the year before, had apparently lost patience with him, and were not prepared to accommodate Nathan, and it appears there was limited contact maintained. When Nathan asked WCSC for contact with his mother, she was apparently unable or unwilling to respond.

Professionals noted a significant decline in wellbeing and mental health and there was renewed involvement with support services. This included involvement with CAMHS from July 2016 (17) to February 2018 (19). He was also referred to substance misuse services in Wolverhampton, a training provider for his education and Intensive Family Support (IFS) for independent living skills. IFS had very frequent, and for periods, daily contact, with Nathan and were able to provide support beyond his eighteenth birthday. They responded to mental health crises and were an important part of the care plan.

Nathan's engagement with other services was often poor; he DNAed three appointments with substance misuse services and was on the point of discharge from the service.

Substance misuse was a factor in Nathan's offending behaviours. He told CAMHS he used cannabis, mamba[4] 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.

Nathan increasingly described suicidal ideation and low mood which led to CAMHS assessments 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'*. The consistent

[4] 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.

refusal by professionals to arrange a scan, which Nathan felt would prove the point he made, was identified as a source of frustration to him.

A CAMHS Early Intervention Service Consultant (Consultant 1) made a 'working diagnosis' of dissocial behavioural disorder[5] which was shared with Nathan's GP and it remained a potential diagnosis into late 2017, however the challenge faced by mental health professionals was always identifying whether the auditory or visual hallucinations and perceptual abnormalities reported by Nathan were psychotic in nature or related to personality disorder, and this was further complicated by the impact of substance misuse.

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. Having exhausted supported housing, WCSC resorted to Bed and Breakfast accommodation, however the same pattern of hostile behaviour re-occurred there; on one occasion he assaulted a Landlady and damaged her car. In the period between February 2015 and his eighteenth birthday, Nathan lived at sixteen separate addresses, including a Young Offender's Institute.

In April 2016, West Midlands Ambulance Service were called to Nathan's flat (17) where he claimed to be *'paralysed'* because of taking an unnamed substance. Whilst treating him in the ambulance, Nathan came round and forced his way out of the vehicle. He then stopped a passing car and punched the driver to the face whilst attempting to take the vehicle. This failed and later, when he returned to his accommodation, he was arrested. He was later convicted of assault with intent to rob.

Nathan was referred to CAMHS by the Youth Offending Team (YOT) in June 2016 and was assessed by a Consultant in Child and Adolescent Mental Health (Consultant 2). The referral from YOT had suggested that Nathan had been talking about '*evil spirits'* and was feeling that '*something wanted to kill him*'. Nathan had indicated that he wanted to '*hurt others'* but that he also did not want to live like this anymore. His YOT

[5] Dissocial Personality Disorder: Dr Colin Tidy & Dr Laurence Nott - Dissocial personality disorder is not formally diagnosed before the age of 18. However dissocial personality disorder often begins early in life, usually by age 8 years. The diagnosis is then initially conduct disorder in childhood, and the diagnosis converts to dissocial personality disorder at age 18 if antisocial behaviours have persisted.

support worker had referred Nathan to CAMHS as he felt concerned that '*Nathan may kill himself, kill someone else or commit a crime.*'

Consultant 2 diagnosed psychosis, low mood and noted the use of cannabis. Nathan was prescribed Risperidone[6]and Sertraline[7]. The Consultant had organised a hospital admission, but due to an improvement in Nathan's presentation, this was not taken up.

In June 2016, Police arrested Nathan (17) after he broke several windows in the premises he was living in. He was later convicted of criminal damage. The same month, whilst at his foster mother's address, her son threatened her with a knife to get access to her car keys and Nathan got into the passenger seat. Stopped and arrested by police, only the foster mother's son was charged with any offences.

In July 2016, Nathan (17) committed a robbery in a shop, pushing over a staff member who was injured, smashing a window, and stealing £100 cash from the till. He was detained at the scene by a member of the public. The Police custody record details that Nathan was subject to a mental health assessment because of suicidal ideation. Nathan stated that his thoughts, feelings, emotions, and actions were all controlled by a '*person*', who commanded him to do bad things. He expressed a wish to end his life by jumping off the roof to defeat this '*person'*. During his detention, he threw food over the floor several times and repeatedly kicked the cell door. On several occasions, he threatened that if released he would attack the complainant responsible for his being in custody. Social services could not offer suitable accommodation, this led to a remand in custody at Werrington Young Offender's Institute for two weeks, which made Nathan a child in care (CIC).

In view of his suicidal ideation, he was subject to an Assessment, Care in Custody and Teamwork (ACCT) risk assessment. The YOTs pre-sentence report (PSR) recommended custody or admission to hospital for assessment. However, the court, guided by the Admission to Care Panel, preferred that post sentence, Nathan be placed in supported accommodation.

On one occasion in August 2016, he was supported by the Intensive Family Support (IFS) worker to go to Emergency Department at New Cross Hospital for a Mental

[6] Risperidone is an anti-psychotic medication.
[7] Sertraline is a type of antidepressant known as a selective serotonin reuptake inhibitor (SSRI).

Health Assessment, where a voluntary admission was organised, but Nathan refused this and discharged. Through the autumn of 2016, Nathan continued to hear voices and express suicidal ideation, and professionals liaised with the CAMHS counsellor. Subsequent CAMHS assessments in the following weeks did not assess Nathan as needing voluntary treatment and he did not meet the threshold for compulsory treatment under section 2 of the Mental Health Act 1983.

In November 2016, Nathan (17) was alleged to have taken his foster mother's car without consent. He returned the car, and she did not want to press charges.

In December 2016, Nathan was eighteen. IFS closed the case in January 2017, not it would seem because help was no longer required, but presumably because Nathan was no longer eligible.

In the following two years, it is evident that Nathan's GP diligently monitored his mental health and made several referrals to MH services to secure the right level of mental health support.

There was a further report in June 2017, that Nathan had caused damage at his accommodation, smashing windows, tearing up a carpet and breaking spindles in the banister.

Nathan had some engagement with the Mental Health Liaison Team, and they reported to the GP in March 2018, that he believed his worsening condition related to being '*kicked out by his father three and a half months ago*.' (There is nothing to corroborate the claim that he had returned to live with his father in 2017; some other claims Nathan made to professionals can be shown to be inaccurate or unreliable, so this claim is hard to place into context.) If as Nathan claimed, he was now living in a hostel, it is possible that it was in Birmingham, because a consistent problem in supporting Nathan in the years under review was that he had a Wolverhampton GP but was trying to access services in Birmingham, where he lived.

A Senior Practice Nurse reported that Nathan had become increasingly reclusive and had been sleeping for lengthy periods; was feeling lethargic and devoid of any energy. Nathan had described hearing '*hundreds of voices'* some internal like his own, that were commanding him to harm others and that there were also external voices which often sounded like people whispering behind him.

Although the Complex Care Team tried to engage with Nathan, he DNAed or failed to make contact and was discharged back to his GP in June 2018.

In June 2018, Nathan was once again involved in an altercation whilst drunk with another resident at the hostel he was residing in. He was correctly identified as a victim, having sustained a cut mouth and chipped tooth, but the matter was later filed, when other residents claimed Nathan was the instigator.

It appears that Nathan was living in a Wolverhampton hostel from December 2018 to April 2019, when he left and told the hostel he was returning to Scotland. This could account for the absence of contact with any agency until the following year.

By May 2020, Nathan was again living in a hostel in Birmingham, when a fellow resident reported to Police threats to kill by Nathan and two others. There were inconsistencies and discrepancies in the stories given and CCTV did not corroborate the complainant's account, and the matter was filed with no further action taken.

At the end of the same month, Nathan presented at the Emergency Department at Heartlands Hospital to talk about suicidal thoughts he was having to hang himself, following an argument with a fellow resident in his hostel. He was advised to register with a Birmingham GP to facilitate accessing support.

In July 2020, Nathan made a call to Police using his own first name and Steve Mason's surname, declaring his intention to harm or kill himself. The conversation recorded with the call handler can be seen to contain inaccurate or false statements, as well as contradictory explanations of his relationship and feelings for his father. He stated he wanted to speak to his father, Steve Mason, before he died. He said his father had done '*nothing from him and was just a sperm donor*'. Nathan claimed to be the father of a child, a girl, whom he had not seen since birth, because she had been taken away from him. There is no evidence that this was the case. His father, he stated, had children with a partner who may answer the phone. This also was untrue, if the 'father' he was talking about was Samuel. Asked for his father's address, Nathan said if he had known that he would have '*petrol bombed it a long time ago.'* Samuel was living in the same address that he had since Nathan lived with him. Challenged about the apparent contradiction in his feelings for his father, Nathan said '*he still loved him and wanted to say his goodbyes.'*

After a search, Police located Nathan and he was taken to a place of safety under section 136 of the Mental Health Act 1983[8]. He was assessed as '*not having any serious mental health issues'.* There was no offer of mental health follow up. He was returned to the hostel by police, where a support worker was updated who undertook to attend to housing 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. The victim had helped Nathan by giving him food because he was '*too drunk to do this for himself*'. Shortly after, Nathan had apparently knocked at his door, claiming the victim *'had his papers'.* He became aggressive, accused the victim of '*disrespecting him'*, and lunged at his chest with a penknife, but the blow was deflected, catching the victim on the neck. He struggled with Nathan, holding his arm to prevent further blows. Due to his intoxication, Nathan fell to the floor and then fled the scene. 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 then 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.

The Crown Prosecution Service authorised Nathan be charged with assault occasioning actual bodily harm (section 47 Offences Against the Person Act 1861), two racially aggravated public order offences, and criminal damage. In court, Nathan pleaded guilty to the racially aggravated offences, but not guilty to assault and criminal damage. He was remanded in custody after the police stated they believed if he were released, he would return to the address and commit other offences. (Police had proposed that should Nathan be released on bail, a requirement to sign on at a police station was appropriate.) Nathan spent around four weeks in prison and was subject to an ACCT assessment by the prison mental health team, but there is little evidence that they either made any progress in identifying the nature and causes of Nathan's mental ill health or identified risk to others upon release. (This missed opportunity is described in the IMHR.)

[8] 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.

In January 2021, Nathan was released on bail and his residence condition was to live and sleep at Address 1. Although imposing a condition to report regularly at a police station was open to the court, as proposed by the Police in December, they chose not to make this requirement. The third COVID restrictions were in place (06 January 2021 to March 2021) at this point, and this may have influenced their decision. There is no evidence that Police attended the bail hearings, so it would have been a decision for the Crown Prosecution Solicitor present to re-address this specific bail condition. Nathan remained on bail up to the date of the homicide. Being on bail meant he should not move permanently from his bail address, without the court agreeing any new address.

However, by March 2021, Nathan had moved to Address 2 without seeking the court's approval, and a support worker called police to report a confrontation between Nathan and another resident. The support worker was mediating the dispute by phone and had heard one or other of the men threaten the other with being stabbed. The support worker informed the call handler that Nathan had similar offending in his antecedent history. The WMP IMR author established that routine checks carried out by Police call handlers identified that Nathan was on bail, and this should have been communicated to the officers attending, although there is no evidence this was done.

In circumstances that were remarkably like his bail offence, Nathan had accused the other of stealing his wallet, and a fight had ensued. Nathan could offer no evidence to substantiate the allegation. Both men denied making the threats that had apparently been overheard. The Police recorded crimes of assault for both men and a crime of burglary. Had officers carried out full intelligence checks on Nathan, and given he was a named offender in a crime report, that would be a normal minimum expectation, they could have identified he was on bail to reside at Address 1 and that he was in breach of his bail. That this did not happen was a missed opportunity.

Two days later, at 21:30, a 999 call to Police was made, reporting a man had climbed over a fence into a back garden. It was Nathan, who was intoxicated and claimed to be looking for his phone. The officers apparently accepted this account and returned him to Address 2. Intelligence checks should be carried out on a person identified as acting suspiciously and the fact they did not discover Nathan was on bail, would appear to have been a second missed opportunity within one week, for police officers to discover this breach.

In early May 2021, GP1 had the first contact with Nathan since 2018. Although the surgery had received notifications about the mental health incidents mentioned above, and were notionally supervising Nathan's mental health, there had been no recent direct contact. Nathan claimed to be feeling low having recently lost his mother and brother. (This was not correct regarding his mother, who was alive. He, later the same day, told a Mental Health Nurse she had been diagnosed with cancer.) He told GP1 he was hearing voices telling him to '*kill people'*. GP1 contacted the Mental Health Liaison Team in Birmingham, but they could not offer more than an appointment in four days, so they advised Nathan should attend the Emergency Department by ambulance. It appears that GP1 had been told by Nathan he had recently been released from custody and was '*on bail for an attempted murder of a stranger'*. This was shared by the GP with West Midlands Ambulance Service (WMAS), who consequently asked for Police attendance.

Nathan repeated the claim that he was on bail for attempted murder, whist being assessed at the hospital, and this was shared when he was referred to Forward Thinking Birmingham (FTB) a mental health service for young people under 25 years old, able to offer a crisis assessment and support in the community. At hospital, Nathan gave Address 3 as his home address, whilst he told WMAS, he lived at Address 1. Nathan claimed to have spent over £2,000 on crack cocaine since leaving prison.

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. Police allocated the Street Triage[9] team to respond although it was unclear where Nathan was calling from, he identified he was in a specific park. He mentioned that he wanted to speak to his mother, but had no credit on his phone, and that he wanted 'Steve' informed. A search was instigated with officers organising the use of a drone. Police identified an address for Nathan (Address 3) and forced entry to his room, but it was empty. Around an hour later Nathan was found. He claimed to have already made a failed attempt to hang himself; the rope had broken. Police used section 136 of the Mental Health Act 1983

[9] Street triage is a partnership, 24-hour response vehicle, crewed by a Police Officer with additional Mental Health training and a Mental Health Nurse. The officer can use section 136 of the Mental Health Act a Police only power, to intervene in a situation where someone appearing to suffer from a mental disorder and is in immediate need of care or control, where this is necessary in that person's best interests or for the protection of others.

The use of this power may occur where an officer makes their own assessment that it is required. The power can be used in any location, public or private but cannot be used in a private dwelling.

to take Nathan to a place of safety where he was assessed as not requiring detention under the Mental Health Act 1983 and was referred to the Home Treatment Team. It seems likely that Police officers were in attendance during the assessment and returned him to his home, Address 3, since they remained shown as actively involved on the Police Log until 00:23.

In mid-June 2021, Nathan alleged to Police he had been assaulted close to Address 3, as had a friend. The assailant was a drug dealer known as Ninja. Nathan had already sought and been given accommodation at a location unknown to the offender, Address 4, a hostel, which meant he was no longer in immediate danger. He declined to substantiate the offence or identify the second victim, so the Police took no further action. Nathan remained in breach of bail up to the point of the homicide of Samuel.

FTB engaged with Nathan from the date of the referral from the Hospital in early May, until mid-June, seeing him at Address 4 and also at their clinic. They were experiencing the challenges of supporting clients during COVID, an issue addressed in the IMHR. 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.

In 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.

14.0 Overview & Analysis

The chronology in this DHR 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.

The impact of ACEs upon Nathan will be considered below because they appear to be significant in understanding the relationship breakdown, Nathan's worsening drug dependency, and declining mental health in this case. Building resilience and providing appropriate support after toxic childhood stress[10] is critical to achieving positive outcomes in adult life and reducing risk of self-harm or harm to others caused by anxiety, arousal and aggression and impulsive behaviours.

This DHR will identify in **Section 15: Lessons to be Learnt** what professionals can learn from Nathan's history and experience of ACEs, to provide trauma-informed interventions to individuals, that reduces risk to them, but also risk to others. Whilst an understanding of the impact of ACEs is increasingly evident in child safeguarding and support, trauma-informed care for children and adolescents is a relatively new concept in the UK welfare system. It is therefore not surprising that the DHR noted intensive support from WCSC but insufficient concentration on the part trauma played in Nathan's behaviours. Early identification of the impact of ACEs upon a child or young person's emotional wellbeing would go some way to reducing the risk of trauma-related mental ill-health and drug and alcohol misuse in adult life.

Similar weaknesses can be identified in the lack of ongoing support for adults who have suffered ACEs. Emotional distress caused by experiences like those of Nathan: parental rejection, psychological and physical neglect, racism can sometimes be labelled as a mental health 'disorder' which may not be helpful.

The DHR noted some evidence of child to parent violence by Nathan against Samuel, but also earlier in his childhood, against his mother, Jean. The review will draw learning from the circumstances to identify any known links between non-fatal child to parent abuse and parricide.

The IMHR by NHS England attached to this DHR as an Annex considered in detail the support offered to Nathan in relation to his self-harm and his mental ill health, both when detained in custody for criminal matters, or in the community. The DHR was fully supported at panel meetings by one of the NHS England Independent Mental Health reviewers and therefore was able to take an informed view as to whether Mental Health

[10] Toxic Childhood Stress: The Legacy of Early Trauma and How to Heal. Dr Nadine Burke Harris

services had missed opportunities to safeguard Samuel or others from risk posed by Nathan.

14.1 Opportunities to identify Nathan's potential risk to Samuel in this case

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.

The brief time Samuel and Nathan lived together led to conflict and an apparent inability to understand each other's lives and perspectives. The involvement of Children's Social Services from 2014 to 2017 was in response to Samuel's inability or subsequent refusal to meet the needs of Nathan, who from the point they separated, went into a spiral of mental ill health and antisocial behaviour and crime. Social workers, a foster family, support workers in multiple hostels and Landlords would have known Nathan as a young man now estranged from both his father but also his family in Scotland. The extended family in the Midlands whilst initially supportive, soon felt unable to help.

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 and having little or no contact with his mother and half siblings in Scotland, indeed he sometimes described his mother as having died. There is only the uncorroborated claim made by Nathan to mental health professionals, that he and his father had lived together briefly, in 2017. 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. The chronology has identified only one episode where Nathan expressed to police, a year before the homicide, a desire to inflict harm on his father (Section 13, paragraph 42) but this was also in the context of confusing and contradictory statements made about his father at the point of a mental health crisis.

14.2 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 NHS Foundation Trust (FTB) in the IMHR.

If therefore it was unlikely that FTB would have identified a risk to Samuel or others in the community, even had they been aware of Nathan's contact with his father, then it is important to be clear whether the incidents involving the application of Mental Health

powers to take Nathan to a place of safety, represented missed opportunities to identify Nathan's actual risk, through a more intensive assessment conducted in hospital.

The DHR and IMHR considered the incidents within the chronology where opportunities arose to safeguard Nathan and improve his mental health, through compulsory hospitalisation for mental health assessment (known widely as 'sectioning') under section 2[11] of the Mental Health Act 1983. On two occasions, Police officers used section 136[12] of the Mental Health Act 1983 to remove Nathan to a place of safety (Chronology: section 13 paragraphs 43-44 and 54). 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. Where crisis community mental health assessment and support, such as was offered by FTB, is a 'suitable and least restrictive option', this is in keeping with the spirit of the Mental Health Act 1983.

It would be an example of hindsight bias to point to the Mental Health assessment after the homicide (July 2021) and call into doubt previous assessments. As far as FTB were concerned, there was nothing to suggest that Nathan posed a serious risk to himself or others in the period that they were engaged with him. (Early May 2021 to Mid-June 2021). Nathan was able to build positive rapport and engage with

[11] 1) A patient may be admitted to a hospital and detained there for the period not exceeding 28 days in pursuance of an application (in this Act referred to as "an application for admission for assessment") made in accordance with subsections (2) and (3) below.

(2) An application for admission for assessment may be made in respect of a patient on the grounds that—

(a)he is suffering from mental disorder of a nature or degree which warrants the detention of the patient in a hospital for assessment (or for assessment followed by medical treatment) for at least a limited period; and

(b) he ought to be so detained in the interests of his own health or safety or with a view to the protection of other persons.

[12] 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.

professionals assessing him and there was apparently no evidence of an acute or enduring mental illness.

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.

Doctors treating Nathan after his detention in custody, following the homicide, identified relevant information that informed their view that Nathan was now suffering an acute mental illness characterised by psychotic beliefs. This included the belief held by Nathan that Samuel had been 'replaced' with an 'imposter'.

It now appears that Nathan had expressed threats aimed at Samuel that caused concern to his internet-based friend, Steve Mason, but these were not shared with others. Whilst Nathan may have spoken of this delusion about his father to this friend, he was apparently very circumspect when interacting with professionals and never made this belief apparent until after the homicide.

He did have an unshakeable belief that an implant within his body was controlling his emotions and reactions. This was shared at various times with his GP (and prompted a request for mental health support), CAMHS during his teenage years, Police whilst in custody, so this evidence of apparent paranoia was known, and it seems, largely not seen as a risk factor.

It is not possible to say with any degree of certainty that these paranoid delusions were a contributory factor in the homicide. It is quite possible that the homicide was a consequence of Nathan's inability to regulate emotions and his tendency to aggression and violence; he and his father may simply have clashed, as they had many times in the past, leading to the tragic outcome.

14.3 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 in July 2021, probably in the hours after he had killed his father. He was identified by police once as an alleged offender and once as a victim of crime. On another, he was acting suspiciously on private premises. He was also encountered

as someone in mental health crisis, in need of immediate care and control. Whilst on the occasion he was reporting being a victim of crime, it would not be normal police practice to carry out intelligence checks. WMP would be disappointed that on the other occasions, where correct practice should have enabled officers to discover the breach of bail, they failed to do this.

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. A breach of bail identified in the context of a further arrest or charge may have led to a further period of remand in custody (provided the new offence was similar or sufficiently serious.)

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.

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

The DHR considered the quality of social services support provided to Nathan in his childhood and teenage years to identify whether there were any missed opportunities to address the escalating criminal and anti-social behaviour that Nathan exhibited.

The DHR unfortunately was unable to gain sufficient detail of Nathan's early childhood in Scotland because records have been mislaid or weeded. At the time that WCSC began to support Nathan, a Scottish social worker, reviewing available documents, suggested that placing Nathan in secure accommodation had been an 'overreaction'. This cannot be assessed in the context of Nathan's history, due to a lack of information

obtained by WCSC, who also apparently had little understanding of the care Nathan received from his mother before being accommodated.

It does seem that services provided to Nathan were informed by only a superficial shared understanding of Nathan's childhood experiences that had led to social care involvement in Scotland. Trauma-informed practice would recognise the likelihood of challenges to achieving engagement and could have responded more effectively to Nathan's persistent DNAs at Substance Misuse Treatment Services. In 2023, it is to be hoped that engagement would demand a thorough assessment or even a formalised screening for ACEs, but it must be acknowledged that was not the common approach eight years ago.

As a teenager and young adult, Nathan was displaying many of the indicators of a person suffering the emotional and psychological consequences of childhood trauma. When he returned to Wolverhampton in 2014, he needed carefully structured trauma-informed support. It seems that although there was intensive work with Nathan, there was a missed opportunity for more robust decisions based upon better understanding of his lived experience. This will be further considered in **Section 15.2 Trauma-Informed Practice.**

The DHR acknowledged that WCSC 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.

WCSC IMR stressed Nathan was never able to settle in any accommodation in Wolverhampton for long, making his support a constant challenge. His drug abuse and mental ill health led to frequent clashes with Landlords and co-tenants. From Feb 2015 to September 2017, Nathan had fourteen addresses including hotels, hostels, Bed and Breakfasts and supported accommodation. (This pattern of constant moves continued right up until the homicide)

Despite these difficulties, 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 IFS worker who encouraged Nathan to develop the skills needed for independent living. This worker seemed admirably committed to helping Nathan;

contact during periods of identified increased vulnerability was daily. For example, on at least one occasion, the worker intervened directly to try and get Nathan mental health support when he was in crisis, but Nathan declined a voluntary admission. (Section 13 paragraph 31.) The YOT also worked with Nathan during periods of increased offending.

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. More regular CIN meetings would have avoided the risk that professionals were responding to each new incident in isolation, as seems to have been sometimes the case. Whilst the level of multi-disciplinary support appeared appropriate, it was often reactive. There is little sense of a structured plan.

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. (This goes beyond the statutory guidance recommending CIN meetings every three months/12 weeks) For this reason, the DHR does not propose to make any recommendations in relation to WCSC based upon this learning.

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.

Whilst CAMHS remained available and supporting Nathan as a young adult, WCSC did not effectively transfer Nathan to Adult Services; a scheduled meeting did not take place. (It should be noted that Nathan generally chose not to engage with adult mental health services, until he was in crisis.) That said, since Nathan had neither care or support needs, nor learning or physical disabilities there would be no continuing

support, akin to the help he had received in his late teens. If Nathan chose to disengage, it was unlikely that any professional would see him or consider his needs in a holistic way.

15.0 Lessons to be Learnt

15.1 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.

Nathan claimed both his mother and stepfather resorted to physical abuse. He also alleged intrafamilial sexual abuse. These were claims that the DHR could not corroborate. A half sibling abused drugs which caused family tensions and frequent contact with the Police in the family home.

He experienced parental separation at a young age and subsequent parental rejection by both his birth parents. Neither would meet their parental responsibilities for Nathan, in his formative years. At 13-14 years old, he spent many months in secure accommodation for what appeared to be his care and control, rather than because of offences of violence or risk to others.

After moving to Wolverhampton, he had hope for a fresh start with his father whom he had idealised as the 'solution' to his problems, but the relationship soon became very fractious. It is not difficult to imagine the emotional impact on his wellbeing, caused by experiencing further rejection. The continuing psychological distress caused by rejection in childhood appeared to be evident in adult life when he spoke to professionals about his parents.

A study[13] considered the impact of what is called the Parental Acceptance–Rejection Theory '(PARTheory) may be applied to explain the consistent link between neglect

[13] Rohner RP, Khaleque A. Testing central postulates of parental acceptance/ rejection theory (PARTheory): a meta-analysis of cross-cultural studies. J Fam Theory Rev. 2010;2(1):73–87.

and psychological distress. According to the theory…*perceived parental acceptance or rejection affects psychological adjustment in childhood. In addition, when parental rejection that occurred in childhood is recollected later in life, it is likely to be associated with the same form of psychological maladjustment in adulthood.*

It seems clear that in childhood and adolescence, Nathan had to contend with the toxic stresses of multiple ACEs, as described by Dr. Nadine Burke Harris[14]. '*Toxic stress response can occur where a child experiences strong, frequent and/ or prolonged adversity - such as physical or emotional abuse, neglect, caregiver substance abuse or mental illness. Exposure to violence and/ or accumulated burdens of family economic hardship without adequate parental support. This kind of prolonged activation of the stress-response systems can disrupt the development of brain architecture and other organ systems and increase the risk for stress-related disease and cognitive impairment well into the adult years.'*

A recent study[15] makes it very clear that ACEs impact upon general wellbeing into adult life: '*ACEs are not only associated with poor mental health but also lower wellbeing. This is an important distinction as wellbeing and mental health outcomes tend to have low or moderate correlations with each other, as found in our study. Hence, the absence of mental illness does not necessarily equate to a happy and fulfilling life and ACEs appear to reduce the ability to live one's life to their full potential.'*

The rich body of work available would suggest 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.

In relation to substance disorders and mental ill health a study by Dube[16] suggested *'other adverse childhood experiences may also play a role in the development of*

[14] Toxic Childhood Stress- The legacy of early Trauma and How to Heal. (Dr Nadine Burke Harris)

[15] Adverse childhood experiences and multiple mental health outcomes through adulthood: A prospective birth cohort study. Dawid Gondek[a, *], Praveetha Patalay[b,c], Rebecca E. Lacey[a] [a] Research Department of Epidemiology and Public Health, University College London, London, England, UK

[b] Centre for Longitudinal Studies, Department of Social Science, UCL Institute of Education, University College London, London, England, UK

[c] MRC Unit for Lifelong Health and Ageing, Department of Population Science and Experimental Medicine, University College London, London, England, UK

[16] (Dube et al., 2003) Dube SR, Anda RF, Felitti VJ, Chapman DP, Williamson DF, Giles WH. Childhood abuse, household dysfunction, and the risk of attempted suicide throughout the life span: findings from the Adverse Childhood Experiences Study. Journal of American Medical Association 2001;286(24):3089–3096.

substance use disorders. A retrospective cohort study of 8,613 adults showed that individuals who experienced five or more adverse childhood events were seven–ten times more likely to report illicit drug use and addiction, with the attributable risk fractions for ACEs being 56% and 63%, respectively.

The ACE Study itself showed that the risk of suicide attempts increased two to five-fold with experiencing any ACE and an ACE score of four or more was associated with increased risk of attempted suicide, lifetime depressive disorders and poor mental health in general.'

Pearlin et al.[17] put forward the theory of stress proliferation, a process through which stress begets stress; exposure to serious adversity in childhood increases the risk for later exposure to additional adversities.

There is an established correlation between mood disorder and substance misuse which was described in a study by Douglas and Chan[18]: '*We examined the role of a variety of ACEs on the risk of adult substance dependence (SD). We hypothesized that greater childhood trauma (i.e., violent crime, physical abuse, sexual abuse), the presence of substance use in the childhood household, and lower stability in the childhood home (as evidenced by a negative perception of family relationships, multiple caregivers, and multiple relocations) would be uniquely predictive of SD. Second, we predicted that multiple childhood traumas would increase SD risk in a cumulative fashion. Finally, because mood and anxiety disorders co-occur frequently among individuals with SD, we hypothesized that such disorders mediate the relations between ACEs and SD risk, findings that could inform efforts to identify and intervene with young adults to reduce the risk of SD.'*

The diagnosis of Nathan experiencing psychosis was established after the homicide, but it is arguable that over the years, Nathan manifested clear signs of psychosis. Stanley Zammit, a Psychiatric Epidemiologist from the University of Bristol in a recent online discussion described his recent research project into the links between

[17] Pearlin LI, Schieman S, Fazio EM, Meersman SC (2005) Stress, health, and the life course: some conceptual perspectives. J Health Soc Behav. 2005;46(2):205–19.

[18] Kara R. Douglas & Grace Chan, et al (2010) Adverse Childhood Events as Risk Factors for Substance Dependence: Partial Mediation by Mood and Anxiety Disorders. National Institutes of Health *Addict Behav*. 2010 January; 35(1): 7–13. doi: 10.1016/j.addbeh.2009.07.004.

psychosis and ACES: '*All types of abuse, irrespective of their nature, were associated with a higher risk for psychosis,*' said Zammit. "*The more types of abuse that you were exposed to, the higher the risk of experiencing psychosis. The ACEs study, as well as other research studies, have shown a link between ACEs and psychosis, a severe symptom of mental illness where people can hallucinate and lose touch with reality. These studies suggest that people diagnosed with disorders like schizophrenia tend to report higher levels of childhood abuse and other traumas than the general population.'*

Zammit's findings are consistent with the observations from studies cited above; that there is a dose-response type relationship, meaning the more trauma one experiences, the higher the risk for problems.

The learning from this DHR relating to ACEs is clear and has been established in multiple studies. The Children's Commissioner observed in 2019: '*ACEs are highly prevalent and largely preventable, with a large room for effective interventions, as estimated 2.3 million children in England live in families with complex needs, out of whom only a third receive established support from statutory services*.'

Hughes et al[19] made similar observations: '*If the association between ACEs and mental health outcomes is assumed to be causal, the most effective population health strategy would involve acting early in childhood to prevent ACEs from happening. This would potentially result in saving great economic and social costs due to their link with increased use of healthcare services and medicalisation, among other socioeconomic outcomes. Up to a third of depression and anxiety is attributed to ACEs, with total costs reaching £465.3 million in Wales and £10.7 billion in England.*'

Recommendation One:

The DHR would recommend that Safer Wolverhampton Partnership share the key findings of this DHR with the Office for Health Improvement and Disparities to inform the national and regional approach to embedding trauma informed practice.

[19] Hughes, K., Ford, K., Kadel, R., Sharp, C. A., & Bellis, M. A. (2020) Health and financial burden of adverse childhood experiences in England and Wales: A combined primary data study of five surveys. BMJ Open, 10.

The opportunities for agencies to positively impact upon a young person's wellbeing are frequently limited as they approach adult life, particularly if, as in this case, there is an absence of family support. Nathan was alone in every important aspect. He was constantly on the move, was never able to settle, which must have impacted on wellbeing. It was even more important therefore that he was offered trauma informed support.

15.2 Trauma-Informed Practice to Build Resilience

Trauma is well described by the Scottish Substance Misuse and Mental Health Services Administration as '*an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social emotional or spiritual wellbeing*.'[20] The Office for Health Improvement and Disparities adopted this definition for England and Wales in November 2022.[21]

In the context of Nathan's childhood and adolescence he experienced what is described by Kinoglu[22] 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 experienced multiple ACEs or toxic childhood stress, over a prolonged period, but was probably unable to process these and build the necessary resilience, due to the absence of a positive relationship with either parent. He had no consistent primary care giver, with whom he could talk through his feelings; his mother's rejection of him and the part she played in the trauma must have been hugely impactive. To then experience another failed relationship with his father probably considerably increased the traumatic impact resulting in substance disorder, mental ill health and offending behaviours that were present in Nathan's late teens and early adult life.

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

[20] Trauma-informed Practice: A toolkit for Scotland (Scottish Government)
[21] Guidance: working definition of trauma-informed practice
https://www.gov.uk/government/publications/working-definition-of-trauma-informed-practice/working-definition-of-trauma-informed-practice

[22] Kinoglu S, Nelson-Dusek S and Skrypek M (2017) Creating a trauma-informed organization. Saint Paul, MN: Wilder Foundation. Available online: www.wilder.org/wilder-research/ research-library/creating-trauma-informed organization

aggression and offending behaviours. These reactions are described by Blaustein and Kinniburgh[23] as '*the assumption of danger.*' They argue, '*all of us hold assumptions that are formed by the collective pool of our experiences in the world...and these assumptions guide our interpretation of events, particularly when those events are ambiguous or uncertain: when in doubt, our previously developed systems of meaning guide us.'* They explain, *'for children who have experienced repeated stress, chaos, danger, and harm in their relationships and their environments, these assumptions may be rigid and generalised. It is not that* one *individual is dangerous,* all *individuals are potentially dangerous.'*

Although the last two years of his childhood saw the most intensive multi-agency involvement, it was largely reactive to events, rather than structured to take a trauma-informed view of Nathan's needs and identify how to achieve a trusting relationship. Perhaps only the IFS worker came close, but unfortunately their engagement ended only a month after Nathan turned 18. The reality is that services used by children and families are serving children and families who have been exposed to complex trauma. Although there is widespread exposure to trauma which impacts upon the risk to children and caregivers, the services still have limited training and confidence in providing trauma-sensitive and trauma-informed practice.

The ability of services to provide trauma-informed practice is crucial because without it, the chance of resilience and recovery being achieved is greatly reduced. The availability of trauma-informed support for children and adolescents would offer real hope that lives could be changed. Blaustein argues, ' *as our understanding about the impact of complex trauma grows, so too does our capacity to change outcomes*.' Blaustein's hope is that through such support '*the ultimate goal of the child clinician is not a reduction in pathology, but rather a targeting and building of the core developmental competencies, the system of meaning, and the safe care giving system that will allow the child to build a positive future.'*

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. This DHR would argue the earlier such trauma-informed practice is available, the greater the chance that real positive change can be achieved

[23] Blaustein and Kinniburgh: Treating Traumatic Stress in Children and Adolescents

during the period of the brain's development where plasticity and adaptability are recognised to be strongest. (From birth to the early twenties).

The DHR noted evidence that trauma-informed practice has developed in the years since Nathan's contact with the Criminal Justice system in 2016, led to a period of detention in a Young Offenders' institute (YOI) (section 13, paragraph 26). There were early opportunities to identify the impact of trauma upon Nathan's offending behaviour, however the contacts he had with YOT 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 Youth Offending Services (YOS) and are recognised in inspections of YOTs to be effective. The trauma-informed organisational framework within YOS is based on ARC (Attachment, Regulation, Competency), first described by Margaret Blaustein and Kristine Kinniburgh.[24] It is used within its' assessment models and as a basis for the service delivery within YOTs.

In relation to attachment, the framework focuses on strengthening the caregiving system surrounding children and adolescents through enhancing support, skills, and relational resources for adult caregivers. Regulation emphasises cultivating youth awareness and skill in identifying, understanding, tolerating, and managing internal experience. Competency addresses key factors associated with resilience in stress-impacted populations.[25] It is not hard to identify how this framework could have assisted in assessing Nathan's serious lack of parental or carer support, his inability to exercise self-control because of trauma, and lack of resilience and coping strategies.

Since 2015, YOS' nationally have developed a far more holistic approach to their work. A National Review of the YOS conducted by Youth Justice Board[26], recognised that prevention and diversion are key roles of YOTs. The report noted the core activity of YOTs is specialist oversight of complex and high-risk children and young people in the

[24] Blaustein and Kinniburgh: Treating traumatic stress in children and adolescents (2010)
[25] https://arcframework.org/what-is-arc/
[26] Youth Offending Teams: making the difference for children and young people, victims and communities (Youth Justice Board 2015)

Criminal Justice System. This requires quality individual assessments and intervention planning as well as both safeguarding and public protection.

An inspection of Wolverhampton YOT[27] in February 2022 rated the service '*good'* overall with staff and partnerships assessed as '*outstanding'*, which gives the DHR grounds to believe that a young person meeting YOT today, would receive an improved and more trauma-informed, holistic level of support. For example, an assessment by YOT in 2023, informed by the ARC framework, would highlight the risk to a young person like Nathan whose living arrangements were so precarious.

The Wolverhampton YOT Inspectors noted: '*The trauma-informed approach is reflected in the range of interventions available. These were personalised to best meet the needs of the child'.* The quality of assessments of children and adolescents was rated '*good'* with '*well-informed, analytical and personalised'* assessments.

YOT in Wolverhampton have developed the DIVERT protocol; a joint endeavour to promote the diversion of young people away from the Criminal Justice System using a Joint Decision-Making Panel (JDP).

The JDP was established in November 2021 and aims to provide a multi-agency process to agree appropriate outcomes for referred young people. This includes the option of a diversionary outcome that can avoid unnecessary contact with the Criminal Justice System and promote the decriminalisation of young people wherever appropriate. In addition, it allows for a holistic assessment of young people's needs and the delivery of tailored interventions that promote positive opportunities as well as effectively preventing reoffending.

The JDP has a core representation of a YOT Manager, YOT Assessment Author, Youth Crime Officer, Restorative Justice Worker, Early Help, and is supported by a YOT Administrator. Where identified as appropriate representatives from Barnardo's, Education, Liaison and Diversion, CAMHS, Speech and Language, and Health also attend.

The DHR was assured that since the JDP was established, the Panel has been well attended by a range of professionals which allows for a holistic approach and well-

[27] Her Majesty's Inspectorate of Probation. An Inspection of Youth Offending Services in Wolverhampton (February 2022)

informed decision making. All the young people discussed at panel have avoided court, and all are engaging with the process.

In view of the evidenced development of trauma-informed practice within YOS, and local proven good practice by YOTs, the DHR did not feel there was a need for recommendations in relation to children and young peoples' access to trauma-informed practice within the Criminal Justice System.

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.

Services need to recognise that trauma impacts upon a person's world view and relationships. They may find it difficult to feel safe within services and to develop trusting relationships with service providers. That mistrust may manifest in the behaviours so often seen in Nathan, hostility, lack of motivation, or resistance.

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, Substance Misuse Treatment services.

In adult life, Nathan encountered Criminal Justice Services when he repeatedly offended, and mental health support when he threatened or attempted suicide. This was further complicated by drug and alcohol misuse. Whilst individual agencies provided support, there was little evidence of a personalised care plan agreed in a multi-agency context. It seems the trajectory of Nathan's life in adulthood was increasingly dictated by the failure to properly respond to Nathan's experience of early trauma and re-traumatisation in adolescence.

The NHS Long Term Plan[28] in August 2019 promised, '*a new community-based offer will include access to psychological therapies…personalised and trauma-informed care'*. This was re-stated later the same year in the NHS England Community Health Framework for Adults and Older Adults[29].

The framework champions personalised care plans, 'so *that people who use services…do not feel and experience any gaps and boundaries.*' The framework also recognises '*people who have co-occurring drug and/or alcohol-use disorders and*

[28] NHS Long Term Plan section 3.92

[29] NHS England » The community mental health framework for adults and older adults

mental health needs can also experience discontinuities in their care. The report identified, *'embedding expertise and building skills that provide support for co-occurring drug and/or alcohol-use disorders is a key element of NHS England's Long Term Plan ambition to create a new community-based offer.*'

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. The new definition explains; '*trauma-informed practice aims to increase practitioners' awareness of how trauma can negatively impact on individuals and communities, and their ability to feel safe or develop trusting relationships with health and care services and their staff. It aims to improve the accessibility and quality of services by creating culturally sensitive, safe services that people trust and want to use. It seeks to prepare practitioners to work in collaboration and partnership with people and empower them to make choices about their health and wellbeing. Trauma-informed practice acknowledges the need to see beyond an individual's presenting behaviours and to ask, 'What does this person need?' rather than 'What is wrong with this person?'.*

The DHR would recommend that health and care services commissioned in Wolverhampton embed the 'six principles of trauma informed practice': safety, trust, choice, collaboration, empowerment, and cultural consideration' into services and systems.[30]

[30] **Safety:** The physical, psychological and emotional safety of service users and staff is prioritised, by:
- people knowing they are safe or asking what they need to feel safe
- there being reasonable freedom from threat or harm
- attempting to prevent re-traumatisation
- putting policies, practices and safeguarding arrangements in place

Trustworthiness: Transparency exists in an organisation's policies and procedures, with the objective of building trust among staff, service users and the wider community, by:
- the organisation and staff explaining what they are doing and why
- the organisation and staff doing what they say they will do
- expectations being made clear and the organisation and staff not overpromising

Choice: Service users are supported in shared decision-making, choice and goal setting to determine the plan of action they need to heal and move forward, by:
- ensuring service users and staff have a voice in the decision-making process of the organisation and its services
- listening to the needs and wishes of service users and staff
- explaining choices clearly and transparently
- acknowledging that people who have experienced or are experiencing trauma may feel a lack of safety or control over the course of their life which can cause difficulties in developing trusting relationships

Recommendation Two:

The DHR recommends that commissioners of health and care services in Wolverhampton provide assurance to the Safer Wolverhampton Partnership that trauma-informed care forms part of their commissioning framework and that the six principles of trauma informed practice are reflected in services and systems.

15.3 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. One of the rare statistical studies of this form of homicide, was conducted by Dr. Amanda Holt in 2017.[31] The focus of previous parricide studies has been to distinguish between adolescent and adult offenders. Holt cites the work of Heide, a Forensic Psychotherapist, who claimed adolescent parricide was committed by severely abused children, severely mentally ill children, or dangerously antisocial children. This led later studies to argue adolescent parricide '*was a reaction to prolonged maltreatment at the hands of a sadistic and cruel parent, the killing an inevitable and liberating solution.*'[32] Holt argues that subsequent research has reinforced the view that mental illness is the most significant factor in adolescent parricide. Whilst this may often be a significant element of all parricide, it has tended to unhelpfully focus research and understanding of parricide in a way that is not seen in studies of other types of family violence; upon one age group, adolescence, and one dominant cause, mental ill health.

Collaboration: The value of staff and service user experience is recognised in overcoming challenges and improving the system as a whole, by:

- using formal and informal peer support and mutual self-help
- the organisation asking service users and staff what they need and collaboratively considering how these needs can be met
- focusing on working alongside and actively involving service users in the delivery of services

Empowerment: Efforts are made to share power and give service users and staff a strong voice in decision-making, at both individual and organisational level, by:

- validating feelings and concerns of staff and service users
- listening to what a person wants and needs
- supporting people to make decisions and take action
- acknowledging that people who have experienced or are experiencing trauma may feel powerless to control what happens to them, isolated by their experiences and have feelings of low self-worth

[31] Parricide in England and Wales (1977-2012) An exploration of offenders, victims, incidents and outcomes. Dr. Amanda Holt University of Roehampton

[32] Galatzer- Levy (1993) Adolescent violence and the adolescent self (Adolescent Psychiatry 19 p 418-441)

In a later study, Holt and Phillip Shon[33] noted that parricide research to date has been largely carried out by two different disciplines, with clear approaches; Psychoanalysts and Psychiatrists who tend to focus on mental illness, or Sociologists or Domestic Abuse specialists who tend to focus the issue as a problem of '*dysfunctional families*.'

Holt argues that the presence of non-fatal violence between a parent and their offspring should be regarded in a domestic abuse context as part of the continuum of violence in the same way as it is for intimate partner violence or child abuse. She argues that; *'non-fatal violence towards parents gets trivialised as 'teenagers kicking off', while fatal violence towards parents often gets exceptionalised as a rare event presumed to be used by psychopathological factors intrinsic to the offender.'*

The growing awareness of Child or Adolescent to Parent Violence and Abuse (CAPVA) should lead professionals to avoid these oversimplifications, and a recent Rapid Review of the Literature around CAPVA on behalf of the Domestic Abuse Commissioner, conducted by Dr. Victoria Baker and Helen Bonnick[34] argues that an 'ecological model' clarifies the key factors in CAPVA:

- *Factors and processes at the level of child/adolescent are the most common explanations and typically include: CAPVA as part of a wider pattern of aggression, difficulties around poor mental health, neurodevelopmental and emotional- behavioural conditions, substance misuse, and aspects relating to emotion regulation, narcissism, rejection schemas and entitlement*
- *Factors and processes at the level of the family include historic and ongoing domestic abuse and child maltreatment (and its associated impacts), issues around poor parent-child communication, and parenting practices or 'styles' which either lack boundaries/controls or impose too many controls and do so harshly*
- *Factors and processes at the level of the community include young people's peer relationships (violence-endorsing and victimising), as well as stressors relating to school and poverty*

[33] 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

[34] Understanding CAPVA: A rapid review on child and adolescent to parent violence and abuse for the Domestic Abuse Commissioner's Office

- *Lastly, factors and processes at the level of cultural norms relate to gender role socialisation, particularly the gendering of parenthood and the gendering of family violence, and sons' and daughters' reactions to perceived gender roles and identities.*

Many of these factors seem relevant in identifying why conflict developed between Nathan and Samuel, and although it would not have been characterised as CAPVA at that period, the indicators of abuse of Samuel were largely masked by a focus upon child protection concerns, which would have been a very common approach eight years ago.

This DHR has suggested that when Nathan moved to live with his father, they were fundamentally strangers to each other. Some studies[35], Holt explains, '*have drawn on attachment theory to suggest that attachment bonds between caregiver and child have not sufficiently developed in early childhood, producing later emotional disconnect between adolescents and their parent*.'

The potential for conflict between Nathan and Samuel was very real given the ACEs that had been experienced by Nathan and the potential that this would lead him to struggle to regulate emotions and form a positive relationship with his father.

The reported cause of Samuel and Nathan's conflicts reflect the kind of tensions that have been described as '*asking patterns*', which precipitate non-fatal violence towards parents. In October 2014, (Section 13 paragraph 9) the arguments occurred because Samuel was '*unwilling or unable to provide the material things Nathan wanted*' and Samuel felt Nathan was provoking a physical confrontation. Nathan refused to accept his father's rules of behaviour in the home. The next year, April 2015 (16) (Section 13 paragraph 14) there was a physical confrontation over Nathan's demands for money. Although Samuel was apparently the instigator of the physical confrontation, he was wrestled to the floor by his son. Samuel was now clearly stating he was fearful for his safety, and this was probably why he refused to take Nathan back into his home.

Holt describes how '*these sources of conflict reflect the everyday culturally prescribed desires and lifestyles of a particular generation of adolescents and, in and of themselves the requests from young people do not appear to be extraordinary*.'

[35] Conteras and Cano (2014) Family profile of Young Offenders who abuse their Parents. Journal of Family Violence 29 p901-910

In the context of this DHR, Samuel probably had little understanding of the demands of an adolescent boy and Nathan had a similar lack of appreciation of the values and attitudes of a 55-year-old man who had lived largely on his own. Holt argues,' *this would tend to suggest that violence towards parents is not borne of profound pathology, but is a product of mundane family processes, the nature and extent of which are shaped by an interaction between different generational (adolescental/parental) and gendered maternal/paternal pre-occupations.'*

What is clear is that the dynamics of the relationship between Nathan and Samuel would change in adult life. Holt argues, *'conflict between child and parent does not end, once the child reaches adulthood, and the gendered and generational dynamics continue to shift as child and parent transition through life.*' In this case Samuel had identified in Nathan's teenage years, the risk that what he saw as provocation by Nathan, would lead to further physical conflict and removed the risk by refusing to have Nathan in the home.

Holt argues that *'the nature of the parent-offspring relationship... changes throughout the lifecycle, with the consequence that mothers and fathers are most at risk from parricide at different ages and from different identified circumstances. Thus, the parricidal encounter and the source of conflict, which is at its heart, is likely to be shaped by different events, concerns and pressure depending on where in the lifecycle the family members are located.'*

When Nathan re-entered Samuel's life, it is evident with hindsight, the risks to them both were significant. Nathan was regularly misusing substances, was suffering increasing paranoia and suicidal ideation and was on bail for just one of several recent violent episodes. Holt describes a theoretical proposition concerning violence between a parent and an adult child, that seems pertinent in this case. The reluctance to '*fight back'* that parents feel when the aggressor is a child, the fear of being judged an abuser, becomes less inhibiting when the same child is an adult. '*Once the child reaches adulthood, the socio-legal context of the parent/offspring relationship changes and it may be that 'fighting back' becomes more acceptable. This change will inevitably shape the nature and quality of the violence and potentially, the consequences, which may be fatal.'*

The DHR has described the circumstances that led to a father and a teenage son attempting what was to prove an ill-fated reconciliation. Nathan returned to Wolverhampton as a last resort, after years of what appear to have been neglect and abuse. The conflict that rapidly developed between them was not surprising, nor was the fact that they found themselves in physical confrontations. The Police and WCSC responses were of their time; to investigate an assault allegation of Nathan by his father, rather than considering in any structured way the pattern of challenging behaviour that Samuel was experiencing from Nathan and explore its' causes. The removal of a child from his father by WCSC in his mid-teens was clearly a recognition of the risk they both faced from each other.

When Samuel renewed contact with his son in 2021, he was in his sixties, had significant health conditions and was rekindling a relationship with an adult of twenty-two, who had developing signs of psychosis, suicidality and had a long history of impulsive violence and aggression towards other accompanied by significant drug misuse. He apparently saw his '*abandonment*' by his father as a teenager as the pivotal and defining event of his life. It seems fair to conclude that the renewed contact came with evident risk for both father and son. The trigger for the homicide could have been a combination of Nathan's psychotic beliefs concerning Samuel or a mundane argument borne of generational differences and a failure of understanding. The '*parricidal encounter'* at the heart of this DHR may never be fully understood, but the tensions and risks in the family dynamic had been clear for many years.

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.

16.0 Conclusions

The tragic homicide of Samuel by his son occurred days after Nathan had been discharged from the care of community mental health services for the under 25s, FTB. The learning and recommendations relating to Nathan's mental health support were identified by the IMHR (Annex 1). The IMHR recommendations are endorsed by the DHR, and their implementation will be overseen by NHS England who have undertaken to provide updates on progress to Safer Wolverhampton Partnership.

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. Statutory agency involvement with Nathan under the Children's Act 1983 was required in 2015 and 2016, because after either a clash with his father, or criminal offending, Nathan was assessed to be a Child in Need under section 17. For all the hard work by individual agencies the support lacked structure and a clear plan.

The intensive involvement of services ended when Nathan turned eighteen and it is hard to see their withdrawal as anything other than a dangerous 'cliff-edge'. Nathan's needs remained substantial and many of his presenting concerns were largely unaddressed. The one service that had been a constant, IFS, was also withdrawn.

In relation to his mental health, WCSC social workers were reassured that CAMHS would support Nathan until he was 25, and in 2017 and 2018, Nathan (19) was referred on several occasions by his GP to Early Intervention Services (EIS) and the Mental Health Liaison Team, but by June 2018, aged 2, he was disengaging from the Complex Care Team. If Nathan had not developed a trust of services or felt understood, then from then until the homicide, Nathan's trajectory was entirely predictable. He was not seen by his Wolverhampton GPs between 2018 and May 2021; it was increasingly impossible for a Wolverhampton GP to meet the needs of a patient living in Birmingham. No one professional had an overarching view of Nathan's needs and no one professional had a responsibility to manage those needs.

The extraordinarily difficult position that Samuel found himself in when Nathan returned to Wolverhampton as a teenager and even more so when he renewed his relationship with his son in April 2021, can only be imagined. It would be easy to characterise Samuel as having failed Nathan at times when he most needed help to build resilience. However, this DHR would offer an alternative analysis. 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.

Samuel was trying to meet Nathan's needs without the coping strategies the task required.

The significance of the impact of ACEs throughout the life course cannot be overstated, and 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.

17.0 Recommendations

The DHR has been undertaken in parallel with an NHS England IMHR that has made recommendations for Birmingham Women's and Children's 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: The DHR would recommend that Safer Wolverhampton Partnership 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: The DHR recommends that 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	That 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	That 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	

Annex 1: NHS England Independent Mental Health Review

The Independent Mental Health Review conducted by NHS England in parallel to this DHR has not yet been published. A link to the final report will be added to this Annex in due course.