MK TOGETHER
Safeguarding Partnership

EXECUTIVE SUMMARY
DOMESTIC HOMICIDE REVIEW
Milton Keynes
Case of Adult ‘Henry’

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EXECUTIVE SUMMARY

This summary outlines the process taken by a Joint Review Coordinating Panel established on 27 September 2019 under section 9 Domestic Violence, Crime and Victims Act 2004 by the Milton Keynes Joint Review Co-ordinating Panel, independently co-chaired by Gerry Campbell MBE, to review the homicide of 'Henry' aged 86 (at the time of this incident and subsequently his death) caused by injuries inflicted in March 2019 by his son 'Glen' aged 46 years (at the time of the tragic incident).

The statutory DHR process began with a meeting on 27 September 2019 of all agencies that potentially had contact with the victims and the perpetrator prior to the death of Henry. Agencies participating in the Review were:

I. MK Together Safeguarding Partnership Independent Scrutineer and Co-Chair of the Panel
II. DHR Independent Reviewer and Co-Chair of the Panel
III. Local Learning Reviewer
IV. NHSE Level III Independent Reviewer
V. Bedfordshire, Luton and Milton Keynes Clinical Commissioning Group (BLMK CCG) (now BLMK ICB)
VI. Thames Valley Police (TVP)
VII. South Central Ambulance Service (SCAS)
VIII. Milton Keynes University Hospital NHS Foundation Trust (MKUHFT)
IX. Central and North West London NHS Foundation Trust (CNWL)
X. Milton Keynes GP Practice
XI. Milton Keynes Adult Substance Misuse Service (Compass)
XII. MK Adult Social Care
XIII. MK Together Support Team
XIV. Independent DHR Reviewer and support for the Panel's Co-Chair

The process ended when the Panel approved a final version of the review report at a meeting on 24 June 2022.

The principal essence of this review was to establish how well the agencies worked both independently and together, and to examine what lessons could be learnt for the future. Agencies were asked to review all contact from the ***point of their first contact*** with Glen, Henry and/or Heidi but focused in particular (but not exclusively) on the period from the beginning of 2016 to the date Glen assaulted his father Henry leading to Henry's death. This timeframe was set to gather and analyse contact between agencies and the individuals concerned with this Review that may have had an effect on the family. Those agencies that had contact were required to complete Individual Management Reviews (IMRs) for submission to the Panel. The terms of reference for the review was shared with the victim's family at an early stage of the DHR process and were subsequently agreed by the Panel.

The criminal investigation and criminal justice proceedings against Glen concluded with his conviction for Manslaughter on the grounds of diminished responsibility, attempted murder and other offences perpetrated against emergency workers. Glen was sentenced to a Section 37 Hospital Order with Section 41 Restrictions that are without time limit. This means that a court decided that instead of going to prison Glen should be in hospital for the treatment of a serious mental health problem. A Section 37 is called a "hospital order". The judge decided that because of concerns about public safety Glen also needs to be on a Section 41, which is known as a "restriction order". Section 41 of the Mental Health Act 1983 states that a person cannot be discharged from hospital unless the Ministry of Justice or a Tribunal says that person can leave, and such discharge may be subject to certain conditions.

Whilst the DHR Review process was being finalised, the Coroner's Court hearing touching on Henry's death was undertaken between April 2019 and December 2021. The hearing, which was heard by the Chief Coroner for the area concluded with a finding of Unlawful Killing. In addition, the Chief Coroner issued a Prevention of Future Deaths Report pursuant to Regulations 28 and 29 Coroners (Investigations) regulations 2013 and paragraph 7, schedule 5 Coroner's and Justice Act 2009.

The HM Coroner's Report contained the following matter of concern:
"I am concerned that the S.136 Mental Health Act assessment was conducted without full information held by CNWL or discussion with senior police officers and others who

had been involved in the care of the deceased's assailant. There needs to be an urgent review of the operation of S.136 procedures in Milton Keynes."

In accordance with the legal provisions CWL and TVP had 56 days i.e. by 8 February 2022, to respond to the Coroner's Report.

The progress of this Review has been greatly assisted by the parallel Level III Independent Mental Health Review commissioned by National Health Service England (NHSE) to investigate the care provided to Glen leading up to the incident resulting in the death of his father Henry and the serious injuries caused to his mother Heidi.

A Milton Keynes (MK) Together Safeguarding Partnership Local Learning Review ('the Local Learning Review') was also undertaken. A local learning event took place focusing on identifying trends and themes about how the system did or did not work together to maximise the care of individuals, including but not limited to:

- Information sharing
- Multi-agency use of the escalation protocol especially at weekends
- Understanding of agency roles and responsibilities
- Workforce legal literacy with thresholds and boundaries

It is commendable that MK Together commissioned the Local Learning Review to enable the identification of fast time learning with a view to early implementation and to make improvements quickly.

Following Henry's death, his family made a Public Complaint to the Independent Office For Police Conduct (IOPC) regarding TVP's response immediately prior to and after the fatal attack on Henry.[1] The IOPC determined that this complaint should be managed as a Local (Force) Investigation and accordingly it was remitted to the TVP's Professional Standards Department (PSD) for investigation. This local

[1] Information about the Independent Office For Police Conduct can be found by accessing https://www.policeconduct.gov.uk

investigation of the Public Complaint was initially deferred as sub judice because of the criminal proceedings (at the relevant time) relating to Glen.

One aspect of the Public Complaint made was partially upheld and two were not upheld as follows:

- Did the PCs record [Igor's] request that he be the point of contact for the family over the weekend – **Partially Upheld –** In that the [relevant] PC should have ensured that this information was passed on …."

- "22 to 24 March 2019, Failures to obtain an assessment of [Glen's] mental state and subsequent failure to arrange an appropriate assessment and treatment on Sunday 24 March 2019 - **Not Upheld**

- Failure to conduct proper and appropriate risk assessments prior to [Glen's] release from Police custody to the care of his parents - **Not Upheld**

The Central and North West London (CNWL) NHS Foundation Trust also undertook a Root Cause Analysis (RCA), which was further complemented by the NHSE commissioned Independent Review. This NHSE Independent Review was undertaken by an experienced team of mental health professionals led by the equally experienced Anne Richardson. The Panel agreed that the RCA would form CNWL's Individual Management Review report. The RCA identified one care and one service delivery problem, which was assessed as unlikely to have prevented the tragic incident. This NHSE Independent Review concluded that the tragic incident leading to the homicide of Henry and serious injuries to Heidi was not foreseeable. The Review assessed that "Glen alongside the substance misuse problem that led to the severe state of intoxication he exhibited at the time the incident occurred, may also have been developing a severe and enduring psychotic illness". In addition, the independent mental health review team "...did not find that the mental health team failed in their duty to assess and/or treat Glen prior to the incident although we did believe that there were ways that services might be strengthened."

Background information (The Facts)

In March 2019 Glen (a pseudonym) attacked his elderly parents Henry (pseudonym) aged 86; a former car manufacturing worker, and his mother Heidi (pseudonym) aged 79; a retired midwife, at their home resulting in significant injuries to them both and, which subsequently resulted in Henry's death. This tragic incident took place shortly after Heidi had attended Police custody to act as Glen's appropriate adult as he had been arrested and was under investigation for an assault on an emergency worker (police officer) and Racially Aggravated Public Order Act offences. Glen had also been detained under section 136 Mental Health Act 1983.[2]

On a Sunday in March 2019, the South Central Ambulance Service (SCAS) and TVP were called to a report of a serious assault at Glen's parents' address within the Thames Valley area at around 12:40pm. Glen was arrested by Police Officers in the front of a neighbour's property close to the site of the attack. Given the gravity of their injuries Henry was taken to University Hospital Coventry and Warwickshire (UHCW) by air ambulance and Heidi was conveyed to the same hospital by land ambulance. Heidi was subsequently discharged, and Henry was later transferred to Milton Keynes University Hospital Foundation Trust (MKUHFT) by land ambulance. Sadly, Henry succumbed to his injuries and died three weeks later on Sunday in April 2019 whilst he was being treated at MKUHFT. Glen was initially charged with two counts of attempted murder, racially aggravated public order and the assault of an emergency worker. The charge relating to his father's death was later upgraded to murder.

Two days before the attack upon his parents, Glen is described as behaving bizarrely at home and was taken to hospital, where he kicked an emergency worker (a police officer) and was racially abusive.

The Panel considered that whilst there were some areas for improvement for the statutory agencies the tragic events resulting in the death of Henry were not

[2] For details of what Section 136 Mental Health Act 1983 is see https://www.mind.org.uk/information-support/legal-rights/police-and-mental-health/sections-135-136/

foreseeable. The need for frontline officers to better understand the interplay between the National Decision-Making model and the appropriate legislative provisions when addressing incidents involving mental health is apparent. Whilst Mental Health training has been undertaken for/by frontline officers, this now needs to be evaluated to assess whether the learning has brought about the practical and cultural change required.

The omission to complete "Mental Health Monitoring Forms" on the TVP Niche system by some Police Officers in respect of the MHAA is noteworthy. The forms are a useful tool to gather data around timeliness, consultation with AHMP[3], transport requirements, officer time spent with arrestees/patients at medical facilities and so forth. This informs the necessary improvements in Police practice and service delivery; internally, with partners and the delivery of services to service users.

Glen required hospital treatment or assessment and was detained prior to arrival in police custody. This resulted in a "bed watch" handover from the original police officers. No log of the actions undertaken was available and the subsequent risk assessment undertaken regarding Glen did not include police activity or the decisions of healthcare professionals. Any changeover of police officers, together with healthcare assessments at the handover stage must log all actions, occurrences or treatment concerning the detained person up until their detention has been authorised in Police Custody after their arrest or they are returning to custody. This informs risk identification, assessment and management, and other key decision-making regarding the detainee including that required by the Police and Criminal Evidence (PACE) Act 1984. Additionally, information should be provided to and exchanged with healthcare professionals about the person's conduct and behaviour whilst under the supervision of the police. This information may influence health professionals' actions and decisions.

The statutory agencies, notably the GP, the police and mental health services did not fully address their minds to the role of elderly carers and the support that they may require in discharging this responsibility. Glen's elderly parents Heidi and Henry

[3] Approved Mental Health Professional (under the Mental Health Act).

provided Glen with care and support, although they were not officially registered or recognised as carers. Heidi disclosed to the Police in 2016 and 2019 that she could not cope with Glen. Glen may have been living in his own home, but it was Heidi who maintained oversight and supported him, including financially. The absence of 'professional curiosity' of Heidi's role as carer is noteworthy. Section 10 (3) Care Act 2014 defines a "Carer" (sic as) an adult who provides or intends to provide care for another adult (an "adult needing care").[4] There is therefore, a requirement for the MK Together Safeguarding Partnership to undertake work in this area.

Conclusions from the review

This review has identified all the public bodies that had involvement with the victim, the perpetrator and their family. The circumstances revealed in this review reinforce the need for improvements in professional practice and service delivery by individual agencies and by the MK Together Safeguarding Partnership. The recommendations below are, in the main, for the partnership as a whole but organisations have identified internal recommendations that mirror or otherwise complement these. It is suggested that the single agency action plans should be the subject of review through the MK Together Assurance Board.

The DHR Panel has identified the following recommendations:

Local

Recommendation 1: That all agencies report progress on their internal action plans to the MK Together Assurance Board.

Recommendation 2: That the learning from this review should be brought together with the learning from other Domestic Homicide Reviews in Milton Keynes to inform overarching strategy, policy, protocols and practice.

Recommendation 3: That Thames Valley Police should provide guidance for their frontline Police officers and supervisory officers regarding what legislative

[4] Section 10(3) Care Act 2014 accessed via https://www.legislation.gov.uk/ukpga/2014/23/section/10/enacted

powers may be appropriate alongside the National Decision Model to support Police officers and their supervisors in their decision-making when dealing with imprecise Mental Health incidents.

Learning point: TVP's Mental Health Operational Guidance should be extended to recognise that not all circumstances will be covered by section 135 and section 136 Mental Health Act and that Police Officers should be confident and empowered with knowledge to lawfully act in the best interests and safety of the person they are dealing with as well as their own and public safety.

TVP has taken steps since this tragic incident to update its Mental Health Operational Guidance and has implemented a Mental Health Monitoring Form, which provides the necessary data for strategic and operational decision-making.[5] In addition, this Operational Guidance advises officers that when recording mental health incidents they should be completing an Adult Vulnerability template too, for submission to the Multi-Agency Safeguarding Hub (MASH).[6]

Recommendation 4: That Thames Valley Police should evaluate the Mental Health Awareness training that has already been delivered across the Force and assess its impact; how training has changed its officers and staff's behaviour, decision-making and service delivery.

This evaluation should also focus on the completion of the Mental Health monitoring forms, their submission and the decision-making which follows. The guidance regarding these aspects should also be included in TVP's Mental Health Operational Guidance.

Recommendation 5: That the MK Together Safeguarding Partnership, its constituent members and the wider partnership should consider the further enhancement of its whole family[7] practice approach to ensure that the support

[5] Thames Valley Police's Mental Health Operational Guidance was updated at various time between April - December 2020

[6] Thames Valley Police's Mental Health Operational Guidance, para 3.18 (December 2020)

[7] The Whole Family or Think Family Approach enables a whole family picture to be developed and better understood to provide the right services to the right people. This approach aims to identify risks and needs within families at the earliest opportunity and identifying support to address needs and mitigate risks

needs of family members are considered when a person comes into contact with services. This includes but is not exclusive to domestic abuse, mental health, substance misuse and safeguarding.

Learning point for Recommendations 4 and 5: No "Mental Health Monitoring Forms" were generated on Niche by Police Officers in respect of the MHAA. These forms are used to gather data around timeliness, consultation with AMHP[8], transport requirements, officer time spent with arrestees/patients at medical facilities and so forth and are used to monitor the effectiveness of the provision and the demand impact on Police resources. This is then used to inform necessary improvements in Police practice internally and with partners. The long (but not extraordinary) waiting times seen here, both before arrival at the Police Station and later that day, will not have been captured within these processes.

Recommendation 6: That Thames Valley Police should consider creating a form similar to the PAC 41G to log all actions, occurrences, care and treatment of an arrestee who has been taken to a hospital or other setting prior to their arrival at a Police Station.

In addition, it is also recommended that Thames Valley Police should consider the dissemination of relevant information from such a log of occurrences to assist with the decision-making of health and social care providers.

Learning point: Where an arrestee requiring hospital treatment or assessment is detained prior to arrival in police custody, and a "bed watch" is handed over from the original Police Officers with that charge, then subsequent Police Officers must keep a log of all actions, occurrences or treatment concerning the detained person, until their detention has been authorised in police custody. This informs risk identification, risk assessment and other decision-making regarding the arrestee. This includes the decision-making of healthcare and social care engaged in this process. This Review has highlighted the absence of clearly documented records detailing who authorised the use of leg restraints and the duration of their use on the arrestee, and the

[8] Approved Mental Health Professional (under the Mental Health Act).

information sharing between key professionals where an arrestee has received hospital treatment.

Recommendation 7: That MK Together Safeguarding Partnership supports and encourages a culture of 'professional curiosity' and 'check and challenge' across the partnership in the discharge of safeguarding duties to improve learning, behaviours, decision making and service delivery.

Learning point: There are several instances where Heidi, Glen's mother, informed police in 2016 and again in 2019 that she and her husband Henry could not cope with looking after Glen due to their older years, yet her GP, the police and mental health services omitted to recognise that she was a carer and did not refer her to Adult Social Care for a Carer's Assessment to be undertaken. Section 10 (3) Care Act 2014 defines a "Carer" (sic as) an adult who provides or intends to provide care for another adult (an "adult needing care").
Glen may have been living at his own home, but it was Heidi who maintained oversight and supported him, including financially.

Recommendation 8: That the MK Together Safeguarding Partnership's Joint Strategic Needs Assessment encompasses Domestic Abuse (Intimate Partners and Family Related Violence/Abuse) to better understand the prevalence of the problem and its underpinning drivers:

a) **by agreeing priorities and service provision that meet the needs of the people of Milton Keynes and are cognisant of the gaps within partnership working including the need to work in partnership with local people and non-government organisations (NGOs),**
b) **demonstrating a specific focus on older people as carers and victims/survivors of domestic abuse, and**
c) **to inform the delivery of the local Domestic Abuse Strategy and its accompanying action plan.**

Learning point - Such an assessment will allow the strategic partners to determine and better understand the nature, scale, prevalence and dimensions of the problems to better inform service provision, specialist provision, individual and multi-agency

training, partnership structures, gaps in the partnership working arrangements with local people, NGOs and Voluntary sector organisations.

Recommendation 9: That CNWL reviews its on-call arrangements for psychiatrists and other qualified staff to develop its capacity and capability in its resilient response to mental health crises out of hours.

Recommendation 10: That the MK Together Safeguarding Partnership tests its partnership protocol arrangements for their effectiveness outside of recognised office hours including weekends.

Recommendation 11: That the MK Together Safeguarding Partnership reviews the effectiveness of its partnership protocol within 12 months following implementation.

Learning point for Recommendations 9,10 and 11 – In this Review the Panel identified the limitations of the on-call arrangement for psychiatrists at the time of the tragic incident. CNWL NHS Trust, MK Council and TVP Senior Management have already agreed a process to address this issue and to improve communication between agencies. This process also encapsulates the handing over of responsibility between the section 136 MHA assessing team and TVP and includes a summary of reasons why, for example, someone has not been further detained under the Mental Health Act. This information will be provided in writing by the assessing Approved Mental Health Professional to the TVP custody staff as appropriate.

Recommendation 12: That the MK Together Safeguarding Partnership continues to work on addressing the cultural barriers from the differing professional disciplines and agree to the progression of this work following implementation of a recent audit and action plan.

For example, having difficult shared conversations in the collective agency response to overcome any barriers for the effective discharge of safeguarding responsibilities.

Learning Point: Local learning has demonstrated the difficulty amongst local agencies in overcoming their respective cultural barriers in addressing matters collectively. It is clear that whilst statutory agencies were involved in Glen's care and with Henry and Heidi, it is unclear if Glen received consistent and effective Care Coordination.

Recommendation 13: That the local Clinical Commissioning Group (or its successor organisation), working with providers, ensures that where an arrestee receives treatment by one of them, information is given to the Police regarding treatment and medication to allow Police Custody Sergeants to effectively discharge their statutory duties in the care of detainees.

Learning Point: The Police contribution to the DHR has highlighted the absence of 'any documentation' provided by professionals following Glen's assessment at the Section 136 Mental Health Act suite. Such documentation is important to identify on-going health-care needs as well as contributing to the Police custody risk assessment processes.

Recommendation 14(a) – That Thames Valley Police:

(i) works with local partnerships to develop a more considered and effective approach to supporting vulnerable adult detainees being discharged from their custody as well as signposting Appropriate Adults to local specialist support organisations; and

(ii) further develops its approach to the provision of Appropriate Adults particularly for vulnerable adult detainees.

Recommendation 14(b) – That the MK Together Safeguarding Partnership should also consider providing support information and advice to family members of a patient/service user who has been assessed and/or detained under the Mental Health Act.

Learning point for Recommendation 14: TVP provides a Pre-Release Risk Assessment and Support information leaflet of national organisations covering a spectrum of complex needs. Whilst this is understandable as a Police Force corporate response, it does not provide details of more local statutory or voluntary

sector organisations provided to support local service users, families or others assisting them.

Recommendation 15: That the MK Together Safeguarding Partnership leads a multi-agency event and other work, which captures the learning from the actions in the aftermath of the attack in March 2019 and following Henry's death in April 2019.

National

Recommendation 16: That the Home Office disseminates this Overview Report and Executive Summary to the National Police Chiefs' Council's (NPCC) Leads for Homicide Investigation, Family Liaison, Mental Health and Use of Force (regarding the use of hand and leg restraints) and the College of Policing to further develop learning and consider the implications for Police Authorised Professional Practice.

For example, this includes but is not limited to Homicide Investigators (including Family Liaison Officers) taking a trauma-informed approach with surviving family members and front-line professionals.

Recommendation 17: That the Home Office considers updating the Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews (December 2016) to make certain reviews capture the impact of the homicide on family members and the professionals involved.

Learning Point: There is growing evidence of a link between trauma and people's experiences in the systematised approaches and/or responses used by public authorities, which can re-traumatise victims and survivors including family members and witnesses. For families of homicide victims this may also include the sheer volume of professionals that they interact with before, during and after the criminal justice processes as they re-live time and again their experiences. These are areas highlighted by the victim's daughter Kim.