MK TOGETHER
Safeguarding Partnership

DOMESTIC HOMICIDE REVIEW

Case of Adult 'Henry'

April 2019

Authors: Gerry Campbell MBE and Neelam Sarkaria
2022

The Authors and the Joint Review Coordinating Panel would like to express their sympathy to the family and their sincere condolences for the loss of a husband, father and father-in-law. The Independent Co-Chair and authors of this review would like to thank the family, friends, professionals and others who contributed to this Review. The Independent Co-Chair would also like to thank the Joint Review Coordinating Panel and authors of agency reports for their time and thoughtful deliberations, which have contributed to the findings of this Review. In addition, we would also like to extend our gratitude for the kind support of the Milton Keynes Community Safety Team for providing key administrative support.

Victim Impact Statements from family members Kim and Igor can be found at Appendix 5 and Appendix 6 respectively

MK Composite Report Abbreviations

A and E	**Accident and Emergency**
AAFDA	**Advocacy After Fatal Domestic Abuse**
AMHP	**Approved Mental Health Professional**
ASCAT	**Adult Social Care Access Team**
BAME	**Black Asian Minority Ethnic**
CNWL	**Central and North West London NHS Foundation Trust**
CJ	**Criminal Justice**
CPA	**Care Programme Approach**
CPS	**Crown Prosecution Service**
CY	**Calendar Year**
DA	**Domestic Abuse**
DP	**Detained Person**
ECT	**Emergency Call Taker**
EIPT	**Early Intervention in Psychosis Team**

HCP	**Health Care Professional**
IAPT	**Improving Access to Psychological Therapies**
IDVA	**Independent Domestic Violence Advocate (IDVA)**
IMR	**Individual Management Review**
Insp	**Inspector**
IOPC	**Independent Office For Police Conduct**
L&D	**Liaison and Diversion**
LPA	**Local Policing Area**
MARAC	**Multi-Agency Risk Assessment Conference**
MASH	**Multi-Agency Safeguarding Hub**
MH	**Mental Health**
MHA	**Mental Health Act**
MHAA	**Mental Health Act Assessment**
MK	**Milton Keynes**
MKUHFT	**Milton Keynes University Hospital Foundation Trust**
NHSE	**NHS England**
NOC	**Nature of Call**

Obs	**Observations**
OIC	**Officer in the Case**
PACE	**Police and Criminal Evidence Act**
PICU	**Psychiatric Intensive Care Unit**
PSD	**Professional Standards Department**
SAR	**Safeguarding Adult Review**
SCAS	**South Central Ambulance Service**
SCR	**Serious Case Review**
Supt	**Superintendent**
TCA	**Tricyclic Anti-Depressant**
TVP	**Thames Valley Police**
UHCW	**University Hospital Coventry and Warwickshire**
VAWG	**Violence Against Women & Girls**

Description of Systems used by Agencies

The databases and systems interrogated by agencies are listed below:

- **CHARM** – this is part of the call handling system and tracks phone calls by telephone number and records the Police response.

- **Command and Control** is a database and system for managing the allocation and progress of all incidents requiring police involvement. Each incident has a Unique Reference Number (URN) for that date and will be either an 'open' incident which indicates that the incident is still active or shows as 'closed' when the incident has been concluded. There is also a facility to defer a URN for a set period of time. When the deferred period limit is reached the URN becomes open again. This can be used in instances where a future attendance appointment has been made. The URNs will contain a log of events in chronological sequence detailing the history and resources attached to that incident. Data on URNs is searchable and is held for a limited time period on Command and Control. It is then stored on the Command and Control Archive where it can be retrieved in screen or by hardcopy. This data is stored for a 'rolling' seven-year period and after this time period there will be no record of the incident on Command and Control Archive.

- **eCare -** Mental Health Team is expected to record assessments and outcomes on this electronic patient record system.

- **Frameworki -** the Adult Social Care Client Record System. It allows social care professionals access to secure electronic information which details an individual's contact with Social Services.

- **HOLMES** (Home Office Large Major Enquiry System) is a computer application used by Major Crime Unit and others to manage major incidents including murders, serial sexual assaults (including child sexual exploitation), serious fraud and major disasters.

- **Knowzone** is Thames Valley Police's Intranet system, which offers a gateway for information on operational guidance, news, daily briefings, access to databases used for administrative and operational purposes.

- **NICHE** is a system that can hold information about, for example people, places and crimes and since 2012 has been used as a record of a person's time in Police custody. Presently NICHE has taken over as the main system for TVP and existing CEDAR, Intelligence, Missing Persons and custody databases have been combined and are all accessed via NICHE.

- **Police National Computer** (PNC) for history of previous convictions. This system will also record Warning Signals (such as Violent, Mental Health or Ailment and so on). PNC will show whether a person is on bail and any conditions they may have and will also show impending prosecutions. It indicates information such as whether a person is a ViSOR (Violent and Sex Offender Register) subject.

- **Police National Database** (PND) is a national information management system that improves the ability of the Police Service to manage and share intelligence and other operational information, to prevent and detect crime and make communities safer. The PND offers a capability for the Police Service to share, access and search local information electronically, overcoming artificial geographical and jurisdictional boundaries.

- **SystmOne -** is a clinical software system which reflects the NHS vision of a 'one patient, one record' model of healthcare. It allows health professionals access to secure, electronic information which details a patient's contact with health services across a lifetime.

- **Voters register** – this is a database available to Police Officers and staff showing those registered on the electoral roll.

Contents

Please note, the Executive Summary is a standalone document to this report.

1. Preface

1.1 Introduction

1.1.1 This report of a Domestic Homicide Review (DHR) hereinafter referred to as 'the Review', examines the responses of the agencies and support given to Henry (not his real name), a resident of Milton Keynes prior to his death in April 2019 resulting from an attack in his home in March 2019.

1.1.2 In addition to the involvement of the agencies, the Review also examines the past to identify any relevant background or activity before the homicide, whether support was accessed within the community and whether there were any individual or structural barriers denying or preventing the relevant parties from accessing support. By taking an holistic approach the Review seeks to identify appropriate and effective solutions to make the future safer.

1.1.3 The Review focused on the contact/involvement of the agencies with Henry, Glen and Heidi from the beginning of 2016 to the day of the attack in March 2019. Any relevant facts from their earlier lives were included in background information.

The key purpose for undertaking this Review was to:

a) establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims;

b) identify clearly what those lessons are, both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result;

c) apply these lessons to service responses including changes to inform national and local policies and procedures as appropriate;

d) prevent domestic abuse and homicide and improve service responses for all domestic abuse victims and their children by developing a coordinated multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest opportunity;

e) contribute to a better understanding of the nature of domestic abuse;

and

f) highlight effective practice.

1.1.4 The key questions the Panel initially focused as part of the terms of reference were:

- Were there signs or signals that Glen was potentially a risk towards his family members that were missed?
- Were there signs or signals that Glen was potentially a risk towards his family members that were identified but not responded to or communicated to others?
- Was it clear whether Glen when well still needed ongoing support, supervision and oversight or was he only involved with other services when unwell?
- Had agencies identified what Glen's ongoing needs were and was Glen receiving a coordinated level of service when well? Had they also identified whether Glen's family needed input or ongoing support?
- How well did agencies "see beyond" their immediate sphere of professional and legal requirements in order to address the whole situation for the family and local community as well as for Glen?
- Did any of Glen's family ask for help and support or express concerns outside the family about Glen being a threat to them at all. Did they discuss how he behaved towards them with others?
- Were professionals working with Glen aware of the signs and signals that could indicate there was a potential for domestic abuse or coercive control within the family?

1.1.5 One of the operating principles of this Review was to be guided by compassion, empathy and transparency with Henry's 'voice' and that of his surviving wife and family at the heart of the process.

1.1.6 The UK Government has since created a statutory definition of domestic abuse via the recently enacted Domestic Abuse Act 2021.[1] The statutory definition of domestic abuse is in two parts. The first part defines what constitutes violent and abusive

[1] Domestic Abuse Act 2021 accessed via https://www.legislation.gov.uk/ukpga/2021/17/contents

behaviour, whilst the second part details the relationship between the abuser and the abused; detailed in this legislation as ‘personally connected’.

1.1.7 Two criteria govern the relationship between the abuser and the abused. One of the criteria states that both the person who is carrying out the behaviour and the person to whom the behaviour is directed must be aged 16 or over. Of note there is no upper age limit. Abusive behaviour directed at a person under 16 would be dealt with as child abuse rather than domestic abuse. The second criteria states that both persons must be ‘personally connected’. The definition ensures that different types of relationships are captured, including intimate partners, former partners and family members irrespective of sex or sexuality. In this Review the parties are immediate family members. Henry was Glen’s father, and this tragic event took place in a domestic setting i.e. in the parents’ home.

1.1.8 Homicides are recorded as ‘domestic homicide’ when the relationship between a victim aged 16 years and over and the perpetrator (aged 16 years and over) falls into one of the categories, which is recognised by the previous cross definition of domestic abuse i.e. spouse, common-law spouse, cohabiting partner, boyfriend or girlfriend, ex-spouse, ex-cohabiting partner or ex-boyfriend or girlfriend, adulterous relationship, son or daughter (including step and adopted relationships), parent (including step and adopted relationships), brother or sister, other relatives.

1.1.9 The Home Office Homicide Index’s data for the three-year period to the year ending March 2018 show that the majority of victims of domestic homicide were female (74% or 270). This is lower than the non-domestic homicides where the majority of victims were male (87% or 849) and the remaining 13% were female.

1.1.10 In the cases of the 270 female domestic homicide victims the suspect was male in the majority of cases (260). Of the 96 male victims of domestic homicide in the same timeframe, the suspect was male in 50 of the cases and female in the 46 other cases.

1.1.11 The average age of the majority of female domestic homicide victims was 46 years and for male victims was 51 years. In Domestic Abuse Homicide, victims aged 65 years and over formed 6.9% of the total, whilst in non-domestic abuse homicides

this age group formed 18.6% of the total.[2] Of further note, sons/daughters were the suspects in three cases [1 male victim and 2 female victims] recorded over this three years period. [3]

1.1.12 In the year ending March 2019, there were 671 victims of homicide, 33 (or 5%) fewer than the previous 12 months. In 48% of the cases adult female homicide victims were killed in a domestic homicide (99). This was an increase of 12 homicides compared with the previous year. In contrast, 8% of male victims were victims of domestic homicide (30) in the same time period. There were four male victims and nine female victims of homicide involving another family member other than an intimate partner or former intimate partner. [4]

1.1.13 Over the last 10 years there was an average of 82 female victims a year killed by a partner or ex-partner.[5] The largest volume increase was for homicide victims aged 65 years and over, with an increase from 76 to 92 cases. This was due to an increase in female victims in this age category, which rose by 25 homicides (33 to 58). Within this category the largest increase was seen in the number of victims killed by "negligence or neglect" (from 6 to 16).

1.2 Anonymity

1.2.1 In order to maintain anonymity, the various individuals referred to in this Review have been provided with alternative names (to conceal their real identities), which are also known as pseudonyms. The use of pseudonyms also supports, encourages and empowers individuals to participate in the Review. The family has played a key role in selecting the pseudonyms detailed below:

[2] ONS, Homicide in England and Wales: year ending March 2019 accessed via https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/articles/homicideinenglandandwales/yearendingmarch2019
[3] Ibid
[4] Ibid
[5] ONS, Homicide in England and Wales: year ending March 2019 accessed via https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/articles/homicideinenglandandwales/yearendingmarch2019

- Victim - Henry
- Perpetrator - Glen[6]
- Victim's Wife - Heidi
- Victim's Daughter - Kim
- Victim's Son-in-Law - Igor
- Perpetrator's Friend - Chris
- Perpetrator's former partner - Diana
- Neighbour 1 - Nancy
- Neighbour 2 - Mick
- Neighbour 3 - Imogen
- Neighbour 4 - Mandy
- Glen's Solicitor - Linda

1.3 Confidentiality

1.3.1 Details of confidentiality, disclosure and dissemination were discussed and agreed, between the Joint Review Coordination Panel ('the Panel') members during the inaugural Panel meeting on 27 September 2019. The Panel agreed that all information discussed at its meetings was to be treated as confidential and not disclosed to third parties without the agreement of the Panel responsible agency's representative. That is, no material that states or discusses activity relating to specific agencies can be disclosed without the prior consent of those agencies and the Panel's co-chairs. All agency representatives were personally responsible for the safe keeping of all documentation that they possessed in relation to this Review and for the secure retention and disposal of that information in a confidential manner.

1.4 Dissemination

1.4.1 Once finalised by the Review Panel, the Executive Summary and Overview Report will be presented to the Milton Keynes Community Safety Partnership (known as SaferMK). When appropriate, Review Board will sanction the products on the CSP's behalf, and it will be presented to the MK Together Safeguarding Partnership and

[6] the name provided by the Perpetrator was deemed inappropriate by the family and their preferred name has been used

SaferMK for information. Once agreed, the documents will be sent to the Home Office for quality assurance.

1.4.2 The recommendations will be owned by the MK Together Safeguarding Partnership, which will be responsible for disseminating learning through professional networks locally, as well as receiving reports on the progress of the action plan.

1.4.3 Progress will be reported to the MK Together Assurance Board.

1.4.4 The Executive Summary and Overview Report will be shared with the victim's family, the perpetrator, the Review Panel member agencies, the MK Together Safeguarding Partnership and the Police and Crime Commissioner (PCC) for Thames Valley.

1.4.5 The report will be published in line with the statutory guidance, with dissemination to be led by the MK Together Safeguarding Partnership to share the learning from the Review.

1.5 The Review

1.5.1 These events led to the commencement of this Review established under section 9(3), Domestic Violence, Crime and Victims Act 2004, and which was commissioned by the Milton Keynes Community Safety Partnership known as SaferMK[7] to identify the lessons learnt from this tragic incident.

1.5.2 The process of identifying a qualified chair, advertised through the AAFDA network commenced in late April 2019. Gerry Campbell was subsequently selected and commissioned as the independent chair on 24 June 2019.

1.5.3 Following the commissioning process operational planning meetings and consultations were held with the local partnership representatives and the MK Together Partnership team. The inaugural Panel meeting was held on 27 September 2019 when it was agreed that the Panel would be jointly chaired by the DHR Chair and the MK

[7] SaferMK is part of the wider MK Together Partnership arrangements which include the MKT Safeguarding Partnership for children and adults.

Together Independent Scrutineer. There have been 10 subsequent meetings of the Panel to consider the circumstances of Henry's death. Kim and Igor accepted an invitation to present to the Panel on 6 November 2020; the information provided during this interaction can be found in paragraph 4.1.4.

1.5.4 This Review process does not take the place of the criminal or HM Coroner's Courts proceedings, nor does it take the form of any disciplinary process.

1.6 Terms of Reference

1.6.1 The full terms of reference are included in Appendix 1. The essence of this Review is to establish how well the agencies worked both independently and together, and to examine what lessons can 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 will focus in particular (but not exclusively) on the period from the beginning of 2016 to the date Glen assaulted his father, Henry. This timeframe was set to gather and analyse contact between agencies and the subjects of this Review that may have had an effect on the family. Those agencies who had contact were required to complete Individual Management Reviews (IMRs) for submission to the Panel. The terms of reference were reviewed and agreed with the family at an early stage of the DHR process during face-to-face meetings.

1.7 Parallel and Related Processes

1.7.1 The criminal investigation and Criminal Justice proceedings against Glen have been concluded. These proceedings against Glen concluded with his conviction for Manslaughter on the grounds of diminished responsibility, attempted murder and other offences committed against emergency workers whereupon he was sentenced to a Section 37 Hospital Order with Section 41 Restrictions that are without time limit. This meant 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 needed to be on Section 41 restrictions, which is also 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 their discharge may be subject to certain conditions.

1.7.2 The progress of this Review has been greatly assisted by the parallel Level III 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. The Terms of Reference of the Level III NHSE Mental Health Review ('the NHSE Review') can be found at Appendix 2, and the accompanying Level III Report at Appendix 3.

1.7.3 The MK Together Local Learning Review ('the Local Learning Review') has also been undertaken. The Local Learning Review Report has informed this Review.

1.7.4 The MK Safeguarding Board, now the MK Together Safeguarding Partnership received a referral for a Safeguarding Adult Review on 27 March 2019 from Thames Valley Police (TVP). The Case Review Panel determined that the case did not meet the criteria for a Safeguarding Adult Review, however, did meet the criteria for a Local Learning Review. It was agreed a concise Local Learning Review should be undertaken using a blended approach of a review of the agency information provided on request, and a practitioner event/multi-agency learning workshop.

1.7.5 The specific period reviewed was the period covering the critical incident from Glen's arrest in March 2019 until the incident a few days later in March 2019.

1.7.6 The Local Learning Review learning event focused 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

1.7.7 It is commendable that the Partnership sanctioned and commissioned the Local Learning Review to enable the identification of fast time learning with a view to early implementation and improvements made.

1.7.8 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.[8] 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 investigation of the Public Complaint was initially deferred sub judice because of the criminal proceedings relating to Glen.

1.7.9 Two aspects of the Public Complaint made were not upheld and one was partially upheld as follows:

- "22nd to 24th March 2019, Failures to obtain an assessment of [Glen's] mental state and subsequent failure to arrange an appropriate assessment and treatment on 24th 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**

- Did the PC's 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 …."

1.7.10 The CNWL NHS Foundation Trust (herein thereafter referred to as CNWL) also undertook a Root Cause Analysis (RCA), which is complemented by the NHSE commissioned Independent Review referred to in paragraph 1.7.2. The Panel agreed that the RCA would form the Individual Management Review for CNWL.

1.7.11 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

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

(Investigations) regulations 2013 and paragraph 7, schedule 5 Coroner's and Justice Act 2009.

1.7.12 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 CNWL and TVP had 56 days i.e. by 8 February 2022, to respond to the Coroner's Report.

1.8 Panel Membership

1.8.1 The Members of the Joint Review Coordination Panel ('the Panel') formed to oversee the DHR Review, the Level III NHS England (NHSE) Independent Review and the Milton Keynes Community Safety Partnership (MK Together) Local Learning 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. MK 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

(Full details of the Panel Members are recorded in Appendix 4)

1.9 Independent Chair / Overview Report Authors

1.9.1 The Panel was co-chaired by the Review Chair Gerrard (Gerry) Campbell MBE and Jane Held, MK Together Independent Scrutineer.

1.9.2 Gerry Campbell is a former Metropolitan Police Service Detective Chief Superintendent with 35 years' experience of dealing with Community Safety and Public Protection matters focusing on violence against women & girls (VAWG) including domestic abuse and the management of offenders. Since leaving the Police Service he has been employed as a Strategic Programme Lead for VAWG with a London Council and as a Director of Strategy for a Charity supporting South Asian women disowned by their families. In addition, Gerry is an advisor to UN Women, UN International Organisation of Migration, the Royal College of Midwives and is a published author on VAWG/Gender Based Violence.

1.9.3 Gerry is independent and has no connections with individuals or agencies who form part of this review. Gerry retired from policing in November 2016 and he has no personal or professional connections with the Police Officers involved in this case or with Thames Valley Police. Gerry's experience was discussed with the CSP commissioner in Milton Keynes before the review commenced and it was determined that his knowledge would be invaluable in this review process.

1.9.4 Gerry was supported by Neelam Sarkaria in this Review and her role was agreed by the CSP commissioner. Neelam is the former Head of the Criminal Justice Unit at the Crown Prosecution Service (CPS) and now works as a rule of law and gender-based violence expert in the UK and internationally. Neelam is an advisor to UN Women, UN Office of Drugs and Crime and UN International Organisation of Migration and the Royal College of Midwives. She is a published author and recognised subject matter expert on such matters.

1.9.5 Jane Held BA (Gen) is a former Director of Social Services with over 41 years of experience in Social Work, the NHS and the public sector. After retiring from local government service in 2004 she set up an independent consultancy service specialising in safeguarding policy and practice. Previously the Independent Chair of the Birmingham and Leeds Safeguarding Boards and currently the MK Together Independent Safeguarding Scrutineer, Jane has also worked on contracts with a variety of local and national bodies including government and regulators. She has participated in a range of major national reviews and inquiries including the Savile Inquiry. She has authored a significant number of reviews and Serious Cas Reviews (SCRs) over the past 14 years, including three large reviews (two reviews of NHS bodies involving adults with learning disabilities) as an Associate at Verita. She has overseen over 40 different types of review (either SCRs, Safeguarding Adult Reviews, DHRs or learning reviews, across the country).

1.9.6 In conjunction with Gerry Campbell, Jane Held has maintained an independent role throughout this joint review process.

1.10 Methodology

1.10.1 The approach adopted was to seek Individual Management Reviews (IMRs) from all organisations and agencies that had contact with Henry, Heidi and Glen after they had provided chronologies. It was also considered helpful to involve those agencies that could have had a bearing on the circumstances of this case, even if they had not been previously aware of the main individuals involved. Details of those agencies providing IMRs are outlined in the terms of reference.

1.10.2 Once the Chronologies and IMRs were provided, Panel Members were invited to review them all individually and confidentially discuss the contents at subsequent Panel Meetings. This became an iterative process where further questions and issues were then explored. Chronologies and IMRs were obtained from the agencies listed below:

Agency	**Chronology**	**IMR**
Thames Valley Police	Yes	Yes
Central & North West London NHS Foundation Trust	Yes	RCA Report

South Central Ambulance Service	Yes	Yes
Milton Keynes University Hospital NHS Foundation Trust	Yes	Yes
MK GP Practice	Yes	Yes
Compass	Yes	Yes
Approved Mental Health Professionals	Yes	Yes

1.10.3 In addition to the above, interviews have taken place with family members, with Glen's friend and his former partner as well as friends and neighbours of Henry and his wife Heidi as highlighted below. The DHR Reviewers have also been able to view updated strategies, guidance and policies referred to by agencies.

1.11 Contact with family and friends

1.11.1 Henry's family reside in the UK. Henry lived with Heidi in the Thames Valley area for 50 years, with Glen subsequently living on the same street as them after periods of living elsewhere.

1.11.2 The DHR Chair has been the single point of contact with Henry's wife Heidi, daughter Kim and son-in-law Igor through their Advocacy After Fatal Domestic Abuse (AAFDA) advocate.

1.11.3 The Chair made direct contact and conducted interviews with family members, neighbours of Henry and Glen, a former partner and a friend of Glen's. They were able to provide information to the Review, which proved valuable to the process.

1.11.4 The perpetrator Glen was also interviewed by the DHR Independent Reviewer with the Level III Independent Mental Health Reviewer.

1.12 Equality and Diversity

1.12.1 The nine protected characteristics (age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, sexual orientation) as defined by the Equality Act of 2010 have all been considered

within this Review. The Panel agreed that the criteria of sex and age applied to this Review.

1.12.2 Henry, a white European man was born in March 1933. He was born into the Church of England faith. He was a former military man and worked for a car manufacturer. At the time of the tragic incident, Henry had been married to Heidi for 54 years and they lived together in the Thames Valley area for a number of years. Heidi was also seriously injured by Glen in the same attack.

1.12.3 Glen, a white European man was born in December 1972. He has one sibling, an elder sister Kim. Glen was Henry's son.

1.12.4 The Panel identified that the characteristics of sex and age applied to the Review given the sexes of the perpetrator Glen and his victims Henry (his father) and Heidi (his mother). The relationship of the perpetrator to the victims and their respective ages are notable in this Review as there has been an uptick in intra-familial homicide and other serious offending committed by adult sons against parents. The Domestic Homicide Project, commissioned by the National Police Chiefs' Council and College of Police found that in the two-year period 1 April 2020 to 31 March 2022 there were 470 deaths, which took place in a domestic setting or were following domestic abuse, including 43% intimate partner homicide and 22% adult family homicide.[9]

1.12.5 In year two of the Domestic Homicide Project hosted by the Vulnerability Knowledge and Practice Programme, identified that the annual number of domestic homicides increased by 23, with 170 deaths recorded between April 2021 and March 2022. This rise was attributed to an increase in adult family homicides. The suspect was the (adult) child of the victim in 14% (66 cases) of incidents, including the majority of adult family homicide cases (62% in Year 1, 70% in Year 2). In addition of note, between year one and year two there was a 55% increase adult family homicides (+22 cases) and in the same period whilst there was a drop in the proportion of older

[9] Home, NPCC, Vulnerability Knowledge and Practice Programme, Domestic Homicides and Suspected Victim Suicides 2021 – 2022, Year 2 Report, December 2022 accessed via https://cdn.prgloo.com/media/e888f2af12b142449e4eff15c64014ae.pdf

victims (aged 65 years and older) in intimate partner homicide, to 11%, in the adult family homicide cases older people remained a high proportion of victims at 42%.

1.12.6 Additionally, with regards to adult family homicides, in Year 2, 47% of the 62 victims were recorded as female, whilst 53% were male. This was similar to Year 1, in which 48% of the 40 victims were recorded as female, and the remaining 52% as male. The majority of perpetrators in these cases were male. In Year 1 and Year 2, 89% of suspects were recorded as male, whilst 11% were female.

1.12.7 Henry and his wife Heidi were known and remembered fondly in the local community.

1.12.8 In forming the Panel for the Review, consideration was given to the involvement of specific local mental health services that could support this process with expertise. In light of the concurrent reviews undertaken as part of this review process, a wide range of service providers were able to provide information to the Panel including the expertise of the Level III NHSE Independent Reviewer.

1.13 Context and learning from previous DHRs

1.13.1 Domestic abuse is a form of Gender Based Violence/Abuse whereby women are disproportionately victimised by men who are disproportionately the perpetrators. Whilst there is data in this field, it is recognised that domestic abuse alongside other forms of gender-based violence/abuse is both under-reported and under-recorded. There are two sources of data, which highlight part of the picture - provided by the Police forces in England and Wales and the Crime Survey for these countries.

1.13.2 The 42 police forces in England and Wales recorded a total of 1,316,800 domestic abuse-related incidents and crimes in the year ending March 2019. This represents an increase of 118,706 from the previous year.

1.13.3 Of the domestic abuse-related incidents and crimes recorded in the same period indicated in the preceding paragraph, the majority – 746,219 (or 57% of the total) were recorded as domestic abuse crimes i.e. offences against the law.[10]

1.13.4 Such offences include murder, violence against the person (including grievous bodily harm, wounding), threats to kill, rape, other sexual offences, harassment, stalking, coercive control, criminal damage, theft, fraud and so forth. The remaining 43% represent non-crime domestic abuse incidents, which although recorded by the police, do not amount to a crime. For example, the incident could be an argument without threats in a private place e.g. a home address.

1.13.5 Just over one-third (35%) of the 1,671,039 violence against the person offences /crimes recorded by the police in the year ending March 2019 were domestic abuse-related.

1.13.6 In contrast the Crime Survey of England and Wales for the aforementioned period, reports that 2.4 million women and men aged 16 – 74 years old state that they have experienced domestic abuse in the previous 12 months; 1.6 million women and 786,000 men. This equates to a prevalence rate of approximately six in 100 adults.[11] In

[10] This volume of crimes has increased by 24% compared to the previous 12 months' period

[11] ONS, Domestic abuse victim characteristics, England and Wales: year ending March 2019 accessed via https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/articles/domesticabusevictimcharacteristicsenglandandwales/yearendingmarch2019

short, during this period women were more likely than men to be the victims of domestic abuse, which accords with the wider gender-based violence victimisation landscape.

1.13.7 During the period reported, woman aged 20 – 24 were more likely to be offended against as were men aged 16 – 19 years. The data also highlights that a higher percentage of adults experienced abuse carried out by a partner or former partner than by a family member.[12]

1.13.8 Thames Valley Police (TVP) recorded 20,472 domestic abuse crimes in calendar year (CY)[13] 2018, increasing to 23,886 in CY 2019 and increasing again to 28,635 in CY 2020. This represents an increase of 39.9% over the three years reported on.[14]

1.13.9 In the three years 72,993 crimes were recorded with a domestic abuse flag (this does not include non-crime domestic incidents). Of these:

- 82% were violent or sexual offences
- 28% of the total victims were recorded as being male, and
- 4.5% of the total victims were recorded as being over 65.

1.13.10 In addition to the above, in the same period, there were 10 DA homicides in TVP Force Area. Two of these homicide victims were male victims over 65 years; one of whom was Henry. Three of the 10 homicides were adult sons killing a parent.

1.13.11 Milton Keynes has a well-developed multi-agency partnership structure, which reassuringly involves a:

---

[12] ONS, Domestic abuse prevalence and trends, England and Wales: year ending March 2019. Prevalence, long-term trends and types of domestic abuse experienced by adults, based on findings from the Crime Survey for England and Wales, and police recorded crime accessed via https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/articles/domesticabuseprevalenceandtrendsenglandandwales/yearendingmarch2019

[13] Calendar Year is 1 January – 31 December

[14] Some of the increase in recorded Domestic Abuse crimes by TVP can be attributed to the revised Home Office Counting Rules and to the better application of the same by TVP e.g. the requirement for coercive control and harassment/stalking being counted as an additional occurrence where it may co-exist with other forms of domestic abuse. In addition, better identification of DA Crimes by front line police officers is likely to be a factor too.

(i) Domestic Abuse Partnership Board, whose aim is to support the partnerships in achieving 'Milton Keynes is a place where domestic abuse is not tolerated and where everyone can expect healthy and fulfilling relationships'. The Board is supported by a Domestic Abuse Operational Group.

(ii) Assurance Board whose purpose includes obtaining assurance that the learning from review activity is implemented.[15]

(iii) Risk Board whose purpose is: to identify and highlight new and emerging areas of risk. The board has oversight of case-based panels including but not exclusively the Domestic Abuse Multi-Agency Risk Assessment Conference (MARAC) as well as other risk management forums such as Channel Panel, Multi-Agency Risk Management Group and the Vulnerable Adults Risk Management Group.

The Council has developed a Domestic Abuse Prevention Strategy 2020 – 2025 supported by a Delivery Plan.

1.13.12 MK Act is the specialist domestic violence service commissioned in Milton Keynes. The service provides one-to-one support for victims, facilitates access to crisis refuges, facilitates access to perpetrator programmes and has a number of specialist Independent Domestic Violence Advocates (IDVAs).

1.14 Post-Implementation Review

1.14.1 In order to ensure that the recommendations confirmed as being necessary through the Review have been implemented, and that they are achieving the positive impact intended the Panel agreed that a post-implementation audit would be undertaken by the MK Together Safeguarding Partnership 12-months after publication of the Overview Report.

[15] This area of the Assurance Board's purpose will in part be achieved by sharing learning from Child Safeguarding Practice Reviews, Safeguarding Adult Reviews, Local Learning Reviews, and Domestic Homicide Reviews. Any multi-agency training needs are considered by the Safeguarding Partnership.

1.15 Chronology

The detailed Consolidated Chronology for this DHR can be found as follows:

Date	Agency	Nature of Contact	Outcome of contact
Mid-May 2000	**Thames Valley Police (TVP)**	After an altercation in a pub Glen followed victim outside & hit him in the face with a wooden bat causing injury	Glen arrested. Outcome not on Police National Computer (PNC).
June 2006 – mid-June 2006	**TVP**	Harassment by Glen of neighbour. Several calls to police re noise disturbance and 4 notable attendances. Despite being arrested and served with PND, the harassment continued.	Glen was arrested & given a fixed penalty notice for disorderly (PND) conduct. On one occasion an Harassment warning letter issued. Police determine this not appropriate as previous PND issued. Glen was arrested. Released with bail conditions not to attend the neighbour's address. Harassment continued and Glen was arrested and charged. Given bail conditions not to live at his address. Appeared at Milton Keynes Magistrates court in March 2007 and found guilty of Harassment Ordered to pay a fine, compensation and costs. No record of mental health referral.
End of January 2009	**MK GP Surgery**	Glen seen by his GP. Depressed mood with poor sleep pattern & morbid anxiety. No obvious trigger noted.	Was started on named medication by his GP. Only had 1 prescription & did not return for repeat prescription or review.
Early December 2011	**MK GP Surgery**	Henry attended GP with reports of Anxiety and Agitation.	No cause disclosed. Medication prescribed.
June 2013 – Late February 2014	**MK GP Surgery**	Heidi attends GP. Is feeling depressed. Caring for husband and stressed.	Medication regime and counselling provided
End of October 2013	**MK GP Surgery**	Glen seen by GP. Mixed anxiety and depressive disorder. Taking illicit drugs twice weekly and one bottle of wine a night. Recorded involved in court cases	Medication prescribed by GP. Referred to IAPT (Improving Access to Psychological Therapies) in October 2013. Advice given for substance misuse counselling.
End of October 2013	**IAPT**	Glen - Referral rejected by IAPT	Considered more appropriate by IAPT for substance misuse services (CRI).

Mid-January 2014	**MK GP Surgery**	Glen - Reviewed by GP	Glen doesn't feel medication has helped. Agitated and not sleeping. Does not feel drugs and alcohol are a problem
Mid-April 2014	**MK GP Surgery**	Glen - Reviewed by GP	Described as feeling better, more upbeat, no further drugs although sleep still an issue. Sometimes drinks at night to sleep. No suicidal thoughts
Early June 2016 7.59pm	**TVP**	Glen called police stating that whoever is in charge needs to come to his house as he has all the evidence of a breach of his human rights. Officers attended this was a concern for welfare of the male.	Officers report Glen as acting irrationally and communicating to officers on paper. Mental health triage nurse attended. Glen was taken to his parents' house. His mother confirms drinking and off his medication. He was left in the care of his parents. Adult Protection report was completed & submitted to Multi-Agency Safeguarding Hub (MASH). MASH reviewed and decided on no further action.
Same day as previous entry 9.35pm	**CNWL (CPN)**	Police and Street Triage visited Glen at his home address again following a call from TVP. Officers stating that he was presenting in a bizarre manner. Glen became upset when he saw that a psychiatric nurse was present. He left his house and started walking towards his parents', where he was joined by the police officers and Street Triage Team.	Street Triage Team developed the following action plan: 1. Contact his GP and request to have a blood sugar test (query diabetic). 2. Implement sleep hygiene strategies 3. Continue to comply with his antidepressant tablet as prescribed. Refrain from abruptly stopping medicine 4. Glen denied having alcohol dependency hence rejected that he self-refer to either COMPASS or ECLIPSE 5. Glen and his mother were provided with Urgent Advice Line number.
Three days after above incident	**MKUHFT**	Glen taken to A & E by ambulance regarding a convulsion (arrived 10.49am)	Was behaving strangely with ambulance crew. Glen self-discharged before being seen by a doctor. No further documentation recorded.
Same day as above incident	**MK GP Surgery**	Heidi visited GP. Glen had been drinking and was apparently hallucinating. She didn't know where he was and was worried. Neighbours called police.	Heidi was advised that GP Surgery staff didn't know where Glen was. Advised they can access emergency psychiatry service at A&E when found.
Same day as above,	**TVP & SCAS**	Heidi called police reporting that Glen had discharged himself from hospital. He had pulled the cannula	Police attended and found Glen in his garden. His house was smashed up and (he) would not

7.23pm		out of his arm and was running around in the street with no shirt on.	allow officers to come near stating that they would poison his mind. Ambulance requested but delayed. Officers reported that they had detained Glen and were transporting him to MKUHFT hospital. Voluntarily admitted to the Campbell Centre.
Same day as above, 9.35pm	**MKUHFT**	Glen taken to A&E by Police from his home with mental health issues. Documentation doesn't state what MH issues were.	Taken by Police and Mental Health Liaison to the Campbell Centre.
The followin g day, 5.22pm	**TVP &** **SCAS**	Caller to emergency services was Heidi. Glen discharged himself from the Campbell Centre. Described as shouting loudly and upset. Glen states he is very thirsty but thinks the water is poisoned.	Attempts by Police for this matter to be managed by the hospital and security. SCAS were deployed who requested police attendance. Glen refused to go back to A&E voluntarily. Glen failed a Mental Capacity assessment. Refused basic observations to be done. Glen was detained under Section 136 (Mental Health Act) and taken back to the Campbell Centre. The MASH received the above information, which wasn't disclosed further.
Same day as above, 8.14pm	**CNWL (CPN)**	Street Triage Team - Dual Diagnosis Practitioner Glen was visited at his home address following an emergency call from his mother. Glen was sitting outside his garden apparently sunbathing (although it was raining). He had a kitchen knife, beside him saying "the world has gone mad and I have to protect myself in case someone wants to attack me". Glen laughed when the Street Triage Practitioner enquired if he was experiencing self- harming thoughts or thought to harm public. Stated that earlier he visited his GP to get repeat prescription of Fluoxetine 20mg, despite having some. Glen described his temperature as high and he collapsed. He self-discharged (hospital) against medical advice and returned home.	1. Glen was transported to MKUHFT A&E by ambulance escorted by police officers 2. The Unit Coordinator was contacted. The on-call Manager agreed for Glen to be admitted to Hazel Ward (Campbell Centre) on an informal basis. 3. AHTT to complete a gatekeeping assessment for Glen. Impression: Glen's second presentation to Street Triage Team within 3 days. Chaotic presentation, psychotic symptoms noted, earlier Glen collapsed, inability to meet his personal hygiene, loss of functional capacity and deterioration of his mental state. Identified that Glen's elderly parents are unable to support him in the community.

Same date as above – two days later	**Street Triage Team, Campbell Centre**	Glen – acute drug intoxication (cocaine) - Admitted to mental health services by street triage.	Admitted to Campbell Centre. Described as having haptic hallucinations. First night was rude and disruptive - required sedation. Glen self-discharged two days after being admitted
Same date as above	**CNWL**	Admitted to Campbell Centre Psychiatric Hospital On admission Glen was experiencing olfactory and haptic hallucinations and had self-discharged twice before being detained under section 2 MH Act. He admitted to using cocaine in the days prior to his admission and his UDS on admission was also positive for cannabis and amphetamines.	During his admission Glen was treated for psychosis with medication, psychology, Occupational Therapy and nursing support. At the start of admission, he was at times violent and aggressive and had to be transferred to a PICU unit. Glen was assessed by the Early Intervention in Psychosis Team (CNWL). They worked with him and his family before discharge to plan a care package for him in the community. This included benefit & financial work, working with Compass, work strategies, medication and symptom monitoring.
Date of discharge 2016 5.55pm	**TVP**	A neighbour called police concerned about Glen's behaviour.	Police attended with Triage Mental Health nurse. Glen discharged himself from Campbell Centre earlier that day.
Day after self-discharge 10.13am	**TVP & MKUHT**	10.13am. Heidi called to report that her son Glen is currently high on cocaine and is uncontrollable. He has ripped apart things in his house and the caller says he is going crazy. 12.45pm: Member of the public reporting male (identified later as Glen) behaving erratically in street, kicking over cones and nearly got run over. He has been in the pub hugging and licking people. [ED (A&E) Attendance. Section 136 MHA with ?cocaine overdose and acting strangely].	(Response to initial call from mother no longer available and so can't be reviewed). Officers attended second call. Glen "thrashed out" and was handcuffed and put into leg restraints. He was detained under section 136 MHA and taken to A&E and was medically discharged at 4.18pm Glen was taken to the Campbell Centre by police due to his behaviour. Section 136 (MHA) report made. No onward referral made by MASH.

Day after self-discharge	**Campbell Centre**	Glen was brought into the Campbell Centre by 3 police officers in handcuffs and leg restraints (as was thrashing about and spitting). He was stripped of all his clothes after he arrived. Kept in seclusion for the first day of admission as he was using the toilet and drinking from it smearing faeces on the walls.	Admitted to the Campbell Centre. Diagnosed with cocaine intoxication.
End of June 2016	**Compass**	Heidi called as she was worried about Glen. Compass staff were visiting him at the Campbell Centre and undertook to update Heidi afterwards.	
Mid-July 2016	**MK GP Surgery**	Heidi attended the GP Surgery. Was stressed and worried about her son's mental health and husband's health.	
Mid-July to Mid-August 2016	**Compass**	Attempted phone contact with Glen to try to engage with him, which were unsuccessful.	6 Calls made on between July and September 2016 to reach Glen including whilst he was at the Campbell Centre and were unsuccessful. Call end of September 2016 to Glen also un-successful
Mid-August 2016	**Compass**	Compass staff member attends meeting with ASCAT mental health team, Westcroft MH team, Psychiatrist, Campbell Centre with Henry, Heidi and Kim.	
Early September 2016	**Campbell Centre**	Glen was discharged from the Campbell Centre. During admission started with bizarre behaviour, was over familiar with staff & peers and continued bizarre behaviour for 1st month of admission. Physically aggressive, damaged property and sexually disinhibited removing clothes. After coming out of PICU was calmer and more motivated to engage.	Agencies involved in discharge - allocated a care co-ordinator, COMPASS (substance misuse service), Citizens Advice Bureau (re financial issues) and Early Intervention in Psychosis Team (EIPT)
Mid-September 2016	**EIPT**	Glen - Care plan. Marked anxiety rated 7 out of 10 on severity. Management plan made.	See update below dated Sept ’16 – Dec ‘16 Considered more at risk to physical health due to weight gain. Considered low risk of harm to self and others. Medication changed.

Same date as above entry	**CNWL (CPN)**	EIPT - Community Support Glen was seen every week at home or at the team base for support. He was seen 20 times by his care coordinator during this period as well as phone contact. Glen was supported medication, risk monitoring, financial issues, benefits, monitoring his use of substances including and alcohol (he denied using any) family support and symptom monitoring.	Glen was seen four times by the EIP psychologists who worked with him regarding past life events, loss, family relationships and his future plans. Glen later stopped engaging with talking therapy.
Mid-December 2016	**EIPT and** **CNWL (CPN)**	Glen mentions having suicidal thoughts. He had informed the psychologist of this and text messaged his care coordinator.	EIPT and HTT offered support. Glen was admitted informally to Campbell Centre
A week after above entry	**CNWL**	Admitted to Campbell Centre informally for 2 days due to suicidal thoughts - detailed plans to end his life.	Glen was discharged two days later with daily support from the HTT and EIPT.
Sept 2016 – Dec 2016	**CNWL**	Initial CPA review with Dr E. Summary. Glen attended this CPA review. Glen's parents were admitted at the end of this meeting. Glen recalled difficulties with his mental health (depression) and anxiety dating back in to when he was 17 years old. He had a long history of substance misuse mainly cocaine dating back 10 years when he started taking it alongside heavy alcohol use. Mental state presentation described as appearing stable but continues to struggle with restlessness, affecting sleeping routine; increasing his levels of anxiety. He reported episode of low mood and increased anxiety and talked about years of managing them. His medications were reviewed alongside other therapies accessed in the community.	Change to medication. Care Coordinator to liaise with COMPASS to arrange for follow-up sessions at Westcroft Centre every Friday. Care Coordinator to maintain weekly contact to monitor mental state progress and compliance to treatment and liaise with the team. Identified that CPA and risk assessment documentation were to be completed.

Between later in December 2016 and February 2017	**CNWL (HTT)**	Support from HTT post hospital discharge. Glen was seen by consultant psychiatrists, psychologists, nursing staff and support workers. Several joint visits took place between HTT and EIPT	Post-Christmas HTT carried out 25 visits to Glen until he was discharged back to EIPT in February 2017.
Later in January 2017	**CNWL**	Glen did not attend his appointment 12pm. He reported he didn't wish to continue with his psychology sessions as these made him ruminate on the past and made him feel low & unwell.	Glen declined all further psychology sessions.
February – September 2017	**CNWL**	Summary: EIPT visited Glen 22 times over this period. His mental state was much improved and he was much more organised at home. He did not report thoughts of wanting to harm himself or others. Physical health was monitored & his medication was changed. CPA meeting involving family to monitor progress.	Assessed as doing very well and was keeping himself occupied, through some gardening, walking and seeing friends.
Late September 2017	**CNWL**	EIPT- CPA Review took place with the care team and family. CPA and Risk assessment completed. Glen had not experienced any psychotic symptoms and reported avoiding alcohol and illicit substances. He was treated for moderate depression.	Due to change in team personnel Glen was to receive a new care coordinator - CPN 'AK', who would see him monthly.
October 2017 – June 2018	**CNWL (CPN)**	CPN 'AK' made several joint visits with SK to take over Glen's care. She visited him 9 times during this period and also had phone contact. The main activities carried out included monitoring his medication, symptoms, assisting him to undertake more leisure activities, monitoring his physical wellbeing, liaising with his family in monitoring risk and general wellbeing.	Glen denied using any substances during this period and felt he did not need support with this issue.
Early June 2018	**CNWL (NMP)**	Stepped Down from CPA to NON CPA - EIPT NMP CLINIC Glen was seen and reviewed for the first time in NMP Clinic along with his outgoing Care Coordinator. EIP had assessed that a high level	GP Management Plan: 1. Medication reviewed, and Venlafaxine (XL) increased to 150mg mane (28 days prescription for this was given – please supply repeat

		of input is no longer in Glen's care, hence he will therefore be managed on Non CPA. TM will see and review him in her NMP Clinics without extra support from a Care Coordinator role. Glen was involved in this treatment plan changes. Dr E (Consultant Psychiatrist) was involved in the treatment and care review. Glen reported that he has not experienced psychotic or delusional symptoms since 2016 after his discharge from the Campbell Centre. Reports that he continues to struggle with low mood, which doesn't seem to improve with medication. He self-rated his mood at 4/10 (0-low/bad, 10-good/happy). Glen best describes his mood as "don't feel emotions, used to feel happier". Undertook psychological work with EIPT Psychologist 'GH' but did not find it helpful therefore not keen going the same route again. **Medication:** Glen has been taking Venlafaxine (XL) 75mg mane since February after a review with Dr E (Consultant Psychiatrist). Does not feel the dose is sustaining him. Also takes Zopiclone 7.5mg which he uses as and when required - prescribed by GP in short courses. **Physical Health:** Generally, physically fit & healthy. **Healthy Lifestyle Plans:** Healthy eating and regular exercise was discussed at length. Glen is not actively exercising but does small pieces of work with a friend e.g. gardening or building. He also walks a bit. He has a successful construction company in the past. Glen was informed about the Neighbourhood Employment Programme (NEP) but he said that he was not interested. Glen said that he last had alcohol and drugs 2 years previously. At time of	prescriptions). Patient A will continue taking Zopiclone 7.5mg as and when he needs it. 2. Living well including exercise and healthy eating discussed and encouraged. 3. Will now be managed in NMP clinics only, so no further dates booked with AM. 4. Next appointment scheduled for mid-July 2018 or sooner if necessary. 5. Patient A to call EIPT office number as and when required when on annual leave.

		assessment smoked 10 grams of tobacco per week. Not ready to quit smoking. **Risk Assessment and Management:** Glen denied suicidal ideation, no self-harm and no thoughts of harm to others. Parents described as a major protective factor and noted as living on the same street.	
Mid-June 2018 3:00pm	**CNWL (Nurses)**	Physical Health Care Check. Glen attended Westcroft Health Centre for his PHC assessment.	EIPT NMP CLINIC Letter sent to GP fax medication recommendation
Mid-July 2018	**CNWL (NMP)**	EIPT NMP CLINIC Glen was seen at his home address - follow up on the first clinic appointment. Clinic appointments to be predominantly done in Westcroft Health Centre. Glen reported fairly stable mental state in terms of psychotic or delusional symptoms. Apparently not experienced these since 2016. Continues to struggle with low mood, which doesn't seem to improve despite medication dose increase. He self-rated his mood at 5/10 (0-low/bad, 10-good/happy). Glen stated that his anxiety symptoms were "not bad" at the moment. Psycho-education and relapse indicators discussed as part of the **staying well and forward planning.** **Medication:** Glen reported taking his medication Venlafaxine (XL) 150mg. Also takes Zopiclone 7.5mg, which he uses as and when required. Prescribed by GP in short courses. GP usually prescribed him 7 x tablets for the month. Repeat prescription. **Physical Health:** Glen is generally physically fit and healthy.	GP Management Plan: 1. Patient A will continue with Venlafaxine (XL) increased to 150mg mane and Zopiclone 7.5mg (PRN). We looking at another dose review and increase in the next clinic appointment. 2. Living well including exercise and healthy eating discussed and encouraged. 3. Next appointment scheduled for early September 2018. I will see him sooner if necessary. 4. Patient A to call EIPT or Crisis line as and when required when (I am) on annual leave.

Mid-September 2018	**CNWL**	EIPT NMP CLINIC. Glen did not attend clinic appointment on this day and didn't make contact.	
The day after above entry	**CNWL**	EIPT NMP CLINIC. Telephone call to Glen following his clinic DNA (did not attend). Glen said that he was "fine, everything absolutely fine". Stated that he did not have transport to get to WHC. Denied suicidal ideation, no self harm and no harm to others either.	Glen agreed to reschedule appointment to end of September 2018, WHC @ 11am.
End of September 2018	**CNWL**	EIPT NMP CLINIC Glen reports fairly stable mental state in terms of psychotic or delusional symptoms. Reports no change; Struggles with low mood, with little improvement and not finding any enjoyment or gratification. He self-rated his mood at 5-6/10 (0-low/bad, 10-good/happy. Glen said that the anxiety symptoms were "not bad" at the moment. During summer he was going out at least 4 hours a day to help a friend with a garden project which they have since completed. He sees his parents quite often. Glen told the staff he has a sister in her 40s who lives in Peru. He worked in Peru for 3 months before his mental illness. Psycho-education and relapse discussed as part of the staying well and forward planning. **Medication:** Glen reported taking his medication Venlafaxine (XL) 150mg. Also takes Zopiclone 7.5mg, which he uses as and when required. Prescribed by GP in short courses. GP usually prescribed him 7 x tablets for the month. Repeat prescription. **Physical Health:** Glen is generally physically fit and healthy. Stated that he last had alcohol and drugs	Letter sent to GP. GP Management Plan: 1. Patient A will continue with Venlafaxine (XL) increased to 225mg mane today and Zopiclone 7.5mg (PRN) as prescribed by his GP. 2. Living well including exercise and healthy eating discussed. 3. Next appointment scheduled for November 2018. 4. Discussing moving on and step down. To be be referred to PCP (Primary Care Plus) in the New Year to facilitate transition pre-discharge to the care of his GP.

		more than 2 years ago. He currently smokes 10g of tobacco per day. **Risk Assessment and Management:** Glen denied suicidal ideation, no self-harm and no thoughts of harm to others either. Even when low in mood does not have suicidal thoughts. He feels able to seek help and support as and when needed. Parents are a major protective factor. He displayed no signs of agitation or anxiety and maintained good eye contact.	
End of October 2018	**CNWL**	EIPT Psychology: Letter sent to Glen with invitation to attend the "Moving on" Patient Group intervention, starting in early November 2018.	
Mid-November 2018	**CNWL**	EIPT NMP CLINIC Glen reports stable mental state in terms of psychotic or delusional symptoms. Not experienced any psychotic symptoms since 2016. No change. He described it as "neither happy nor sad". He self-rated his mood at 5-6/10 (0-low/bad, 10-good/happy). Glen stated he felt a little on edge with no specific triggers at the moment. Glen states he's been trying to keep himself busy, helping in his parents' garden. He keeps regular contacts with his friends via text messages and calls. Engaging in voluntary activities to help give Glen structure and purpose was discussed. He undertook to research landscaping voluntary opportunities. Glen reported that his psychological state that is affected but did not find psychology helpful at all and wouldn't reconsider it. Psycho-education and relapse discussed with Glen as part of the staying well and forward planning.	Management Plan: 1. Psycho-education and medication reviewed. Prescribed Venlafaxine (XL) at an increased BNF maximum recommended dose of 375mg mane today. Continues to take Zopiclone 7.5mg (PRN) as prescribed by GP. 2. Glen was invited to participate in the Moving On Patient Group but he declined. 3. Living well, exercise and healthy eating discussed as wells as voluntary work (once or twice per week). Seemed interested and said he would research landscaping gardening. 4. Still not keen on talking therapies. He said it did not work for him previously. 5. Next appointment scheduled for later in January 2019 6. Started discussing moving on and step down. Glen to be referred to PCP (Primary Care

		Medication: Glen reported taking his medication Venlafaxine (XL) 150mg. Also takes Zopiclone 7.5mg, which he uses as and when required. Prescribed by GP in short courses. GP usually prescribed him 7 x tablets for the month. Repeat prescription. GASS (Glasgow Antipsychotic side-effect Scale) – no side effects identified **Physical Health:** Glen is generally physically fit and healthy.**Healthy Lifestyle Plans:** Healthy eating and regular exercise was discussed. Usually eats at his parents' house. His sleep and appetite are not bad. **Drug and alcohol intake:** as per entry recorded mid-July 2018. **Risk Assessment:** Glen denied suicidal ideation, no self-harm and no thoughts of harm to others. He feels able to seek help and support as and when needed. Parents are a major protective factor and they live on the same street. He displayed no signs of agitation or anxiety and maintained good eye contact. Spent some time with his sister and parents the weekend gone.	Plus) in the New Year to facilitate a smooth transition to the care of his GP.
End of November 2018	**MK GP Surgery**	Heidi attends GP Surgery. Described as stressed and tearful as everything is getting on top of her. Caring for husband, son and her sister.	Prescribed medication to aid sleeping.
Beginning January 2019	**MK GP Surgery**	Heidi - Ongoing stress. Sister in law passed away. Not sleeping. Started on named medication – stopped after 5 days as developed side effects.	No further relevant medical history on GP records.

Late January 2019	**CNWL**	EIPT NMP CLINIC Text message from Glen @ 09.12am: "Hi .....unfortunately I have picked up a nasty flu like cold over the weekend and will not be able to attend Westcroft this morning. Pls can you make me another appointment, many thanks".	Appointment rescheduled mid-February 2019 @ WHC at 12pm.
Mid-Februar y 2019	**CNWL**	EIPT NMP CLINIC Glen did not attend NMP clinic appointment this afternoon and I did not hear from him either.	Telephone call to Glen at 2.15pm. No responses to messages left.
One day after above entry	**CNWL**	EIPT NMP CLINIC Telephone call to Glen- no response on his phone. A voicemail message was left. Telephone call to Glen's mother too. No response and a message was left.	A letter was sent to Glen asking him to contact the team.
Early March 2019	**MK GP Surgery**	Henry visited his GP as Heidi was concerned about his loss of appetite and weight loss.	No abnormality found on examination. GP records stable mood and communicating well. No mental health concerns. Referred on a 2-week pathway to investigate his weight loss.
Late March 2019	**TVP**	Called to a specified address (known to the review). 15:03 Hours: A neighbour called police reporting that a male (sic Glen) was smashing his house up - shouting and screaming. Caller said that male had an air rifle, which was thrown down the side of the house. Caller described the male as trying to smash windows.	TVP Officers attended and tried to engage with the male, identified as Glen. Reported he was suffering from psychosis and had taken cocaine, cannabis and pain killers. He was arrested for assault on police and racially aggravated public order. He was on 'bed watch' i.e., guarded by police at the hospital overnight. Following a scuffle with police in the morning Glen was then transferred to police custody (arriving at 9.19am a date in March 2019).
Late March 2019 (same	**SCAS**	999 call was received at 3.32pm to attend Glen's address.	Taken MKUHFT hospital for further assessment. He was restrained on the ambulance trolley. The crew arrived at

date as above)		An ambulance was dispatched and arrived on scene at 3.59pm. The presenting complaint was recorded as Psychiatric or Mental Health Act. The history of the presenting complaint highlights that neighbours called SCAS as they heard Glen smashing up his house. The crew recorded past medical history as MH and specifically Psychosis. The crew recorded Glen was an Illicit drug user (cocaine & cannabis). Described as alert, good colour and in Drink. Glen had apparently taken 500 mg of cocaine and cannabis and it was also believed he had taken 4 x 5 mg of diazepam. Glen stated he smashed up his house to make a point.	hospital at 4.47pm and handover of care happened at 6.30pm. Glen had a violent outburst in the ambulance which resulted in him being arrested, he was sexually abusive to the ambulance crew.
Late March 2019 (same date as above entry)	**MKUHFT**	5:36pm: ED (A&E) attendance. Glen brought in by ambulance with police escort. Alleged to be behaving strangely and aggressively and admits to taking cocaine, cannabis and 20 mg Diazepam.	Tests positive for cocaine, cannabis, opiates, benzodiazepines and amphetamines. Diagnosis - queried as psychotic crisis. Determined that Glen required a mental health needs review when fit.
Date in March 2019, after the above entry	**MKUHFT**	Still in ED (A&E). Police remain in attendance as Glen was still exhibiting abnormal behaviours, shouting and being verbally aggressive. He was at this point waiting for a Mental Health assessment.	8:46am: Mental Health Team contacted and are aware of patient. No other entry recorded. On the morning Glen was involved in a struggle with an officer at MKUHFT and was taken to police detention centre.

Date in March 2019, same as above entry 8:46am	**CNWL**	HS attended A&E with the intent to complete assessment with Glen. However, Glen had been taken to police custody as his behaviour in A&E had become unmanageable. [10.00am telephone contact was received from 'paramedic' based in (police) custody who was concerned that Glen had been sent back to custody without any mental health review as there was no-one in the police custody area to complete the review. Advice was provided that in the event that Glen continued to pose a risk to himself then Police could consider placing him on a section 136. This was apparently agreed and would be raised with the (police) Inspector].	Glen was discharged to Police Custody where he remained until his attendance at the Campbell Centre.
Date in March 2019, same as above entry 9.19am	**TVP**	Glen was then transferred to police custody, arriving at 9.19am. After consultation with Health Care Professional (HCP) in custody, an ambulance was called to take Glen to the Campbell Centre for an assessment Under 136 MHA. Left custody in ambulance at 11.00am.	The HCP professional observed his erratic behaviour and it had been advised by duty mental health team that Glen's actions were behavioural or drug induced. No further examination in custody.
Date in March 2019, same as above entry 11:59am	**CNWL** **Campbell Centre (Section 136 MHA Suite)**	Campbell Centre - Section 136 Suite Glen was taken to the Campbell Centre and detained on Section 136 at 11.15am. On arrival at the Campbell Centre section 136 suite, Glen was still in handcuffs and he presented as elated in mood but with no aggressive behaviours displayed. He tried to hug nurses, appeared excitable and overfamiliar. Police and SCAS staff reported that Glen's presentation was a lot calmer and different from the previous day. They felt his mental state had improved quite a lot. The Police stayed with Glen he was under arrest.	Assessment under the Mental Health Act requested from AMHP service. He was discharged from the Campbell Centre having been released from the section 136 at 3.50pm Glen was returned Back to police custody.
Date in March 2019,	**Approved Mental**	On Call Duty AMHP notified by Campbell Centre staff that Glen	

same as above entry 12.45pm	**Health Professional (AMHP)**	had arrived at the Health Based Place of Safety (11:15am) and was subject to section 136 Mental Health Act.	
Date in March 2019, same as above entry	**AMHP**	AMHP spoke with Glen, informed him that his assessment was being arranged asap.	
Date in March 2019, same as above entry 1.35pm – 2.14pm	**AMHP**	AMHP telephoned the on call Consultant Psychiatrist. The Dr requested if a different doctor could undertake the assessment AMHP telephoned a psychiatrist with previous acquaintance with Glen). He was unavailable, but offered a view that the circumstances were surprising as Glen had been well for sometime and did not have significant history of substance use (1.55pm) AMHP contacted another section 12 approved psychiatrist (2.14pm).	A Mental Health Act assessment was arranged for 3.00pm Two Approved Psychiatrists contacted and agreed to attend to assess Glen.
Date in March 2019, same as above entry	**AMHP**	Telephone call made by AMHP to Campbell Centre, Hazel Ward. The outcome of this discussion was a joint decision that the Campbell Centre would not be an appropriate unit to support Glen and manage the risks.	The professionals decided that if Glen was assessed and found to need admission, a Psychiatric Intensive Care Unit may be required.
Date in March 2019, same as above entry 3:45pm	**CNWL and MKCC staff.**	Mental Health Act Assessment Home Treatment Team, 2 Approved Doctors and AMHP attended to assess Glen under the MHA. Glen appeared to engage well. No evidence of psychotic symptoms nor suicidal ideas or plans. Glen said he would be willing to go into Campbell Centre for a day or two, but this was not considered appropriate by the assessors. Glen could not recall what happened the previous day - he admitted he took cocaine and 1 joint at around 12pm. He enjoys taking cocaine, as it inspires him.	Based on the information gathered during the interview and his presentation the assessing team assessed that his presentation was due to illicit substance intoxication. No symptoms of acute mental illness noted. No medical recommendations for admission to hospital were made. Glen was advised to contact EIT and also to engage with COMPASS. Discharged from Section 136 back into police custody at circa 3.45pm

		He also said that the cocaine makes him the person he used to be before he became unwell. Glen stated that hadn't had drugs for 4-5 days before he took cocaine and cannabis the day before. The information suggested he had been taking cocaine for some time. He could vaguely remember that he smashed his property up and stated that he was very emotional about himself and had to let his anger, frustration out. Denied ideas of self-harm, suicide or having delusional beliefs. No formal thought disorder, no abnormal perceptual experiences detected or reported. Glen was alert and oriented to time, place and person.	
Date in March 2019, same as above entry	**AMHP**	Later that day in Milton Keynes Police Custody. Whilst AMHP, Dr HM and Dr DM attended Milton Keynes Police Station Custody (for an unrelated matter) the team were notified by custody staff that Glen was acting bizarrely. Custody were informed that a request for a MHA assessment would be required in order to facilitate any further involvement from the aforementioned MH professionals.	No referral was received and no assessment was undertaken at the police station.
Date in March 2019, day after above entry 12.19pm	**TVP**	Glen was detained and later released from the police station	Glen consulted with a solicitor and an appropriate adult (his mother). He was given medication. Decision fit to detain, but not fit for interview. A pre-release risk assessment was conducted. Level 2 (Raised Level) Glen was released under investigation. Release from custody was at 12:19pm. Glen and his mother were taken to his parents' address by police officers.

Date in March, same as above 12.40pm	**SCAS**	999 call received at 12.40pm. The caller was Heidi although understandably distressed and injured stated that her son had attacked both her and her husband. Her husband was unconscious and she reported on his injuries.	Henry was conveyed to Coventry by air ambulance. Heidi was taken to hospital in a land ambulance.
Date in March 2019, same as above entry 12.46pm	**TVP**	Police generated Information relating to the violent attack 12.46pm Trigger Incident: Call from SCAS that male at address is not breathing having been attacked by son. Ambulance and police attended. Both Henry and Heidi found with significant wounds. Glen was arrested nearby. On admission to custody it was recorded that Glen reported having depression, anxiety, psychosis and that he believed he had further mental health problems that were not diagnosed. Glen reported being cocaine dependent having used 2 days earlier, and wanted to kill himself.	Glen was seen by the Health Care Professional (HCP) in custody at 3.02pm. it was noted that Glen appeared delusional and thought disordered and required a Mental Health Act Assessment (MHAA). At 6.00pm the duty AMHP had called to advise that they will not be performing a MHAA. The civil pathway was determined not appropriate and Glen should be put before the courts. The custody HCP needed a MHAA and the Custody Sgt would be escalating the decision. At 9.53pm it was recorded that Glen would be going to the Campbell Centre for a MHAA.
Date in March 2019, same as above entry	**AMHP**	Discussion if Healthcare Providers at TVP custody, Mountain Healthcare, could make arrangements for further review by Forensic Medical Examiner to identify any change in presentation (in comparison to earlier Mental Health Act assessment) with a view to providing court with a report.	It was agreed that a mental health act assessment was not appropriate due to nature of alleged offence and that a MHA already conducted had identified no acute mental illness.
Date in March 2019, same as above entry 3.15pm	**AMHP**	Telephone call received by duty AMHP from Healthcare Professional on duty at Milton Keynes (Police) Custody Suite requesting an urgent Mental Health Act assessment for Glen.	AMHP advised HCP that she would discuss the referral with colleagues before making a decision on how to proceed.
Date in March 2019, same as above entry 3:29pm	**MK Campbell Centre** **AMHP**	Milton Keynes Police request an urgent MHA Assessment. Background provided regarding release back to Police custody following a section 136 assessment the day before. Communications between AMHP, senior managers and the police take place regarding next steps.	It was determined that Glen needed to stay at the Police station and attend court to go through the forensic route due to the risk he posed and that he had recently been assessed under the MHA and not detained.

		The Police were very keen that Glen was assessed under the MHA.	
Date in March 2019, same as above entry	**AMHP**	AMHP key communications with CNWL Mental Health on-call Manager and the Police: - Section 136 application discussion. If used by TVP then inappropriate a Health Based Place of Safety to be used. -Detective Inspector leaves a voicemail requiring an AMHP to attend Milton Keynes Police Station. -Update telephone call to CNWL's on-call Consultant Psychiatrist. -AL telephone discussion with JT to update her with what MKC had advised the Police. -9:09pm: AL telephone call to AH to explain that a MHA would not be being arranged. AH disagreed with the decision and felt that Glen should be assessed under the MHA. -JT telephoned AG to discuss the case. Discussion centred around the outcome of the earlier MHA that Glen displayed no symptoms of acute mental illness. -AL telephoned AG to discuss the case further resulting in no change in MKC's position with regards to a Mental Health Act assessment. -AL telephoned JT. JT had been contacted by TVP and advised by them that they may make use of section 136 Mental Health Act.	MHAA was subsequently undertaken at the Whiteleaf Centre, Aylesbury.
One day after the above date 1:20am	**CNWL** **Section 136 Suite**	Police detain Glen under section 136 MH Act and conveyed him to the Campbell Centre. This was without prior arrangement. The section 136 suite was occupied but the Police requested that Glen be accommodated there. It was ascertained that the nearest available Section 136 suite was the Whiteleaf Centre, Aylesbury. The Whiteleaf Centre agreed at 00.30am that they could accept Glen for assessment having been made aware of the circumstances.	Whiteleaf Centre agreed at 00.30am that they could accept Glen for assessment. The Police transported Glen to the Whiteleaf Centre where he was assessed under the MHA and deemed not detainable under the MHA. Glen was returned to the Police station.

Same date in March 2019 as above entry, towards end of March	**TVP**	Arrest record - updated details At 00.33am the Police (PACE) Inspector wrote: "I have liaised with the officers who are transporting the Detained Person (DP) to the Campbell Centre …. they have been refused entry and staff have indicated they have been instructed to refuse entry and then stated their section 136 Suite is occupied anyway. Situation escalated to the on call duty manager for MH services and Police Superintendent to liaise with the Director of MH Services. It was recorded that Glen had headbutted the police van cage causing injury to himself - he was seen by an A&E nurse.	At 4:37am Glen returned from the Whiteleaf Centre to custody having been assessed. He was not sectioned. The rationale was recorded that: "They were unable to fully explore his MH state as they did not want to discuss the specifics of the case or the alleged offence therefore this has not been explored." The assessors did not have access to extra information on Glen so couldn't fully assess him. It was recommend that any further assessments take place via Criminal Justice / Court forensic MH services.
Same date in March 2019 as above entry	**TVP**	Arrest record	CPS decision to charge Glen with two counts of attempted murder.
Same date in March 2019 as above entry	**TVP**	Domestic Risk Management Occurrences are recorded on the TVP Niche system.	Two Risk Management Occurrences created in respect of Henry & Glen and Heidi & Glen. However, no further updates completed in light of Glen's remand into custody.
Same date in March 2019 as above entry	**MKUHFT**	00.34am: Glen – ED (A&E) attendance. In police custody. Nose injury ?sustained whilst in police custody.	Department very busy and patient exhibiting behaviours that were considered to be a risk to others by the police. Police returned Glen back to the station. No documentation recorded regarding re-attendance.
One day later than above entry	**Milton Keynes Magistrates Court**	Glen appears at Court in custody; charged with 2 counts of Attempted Murder.	Glen is remanded into Custody.
Early April 2019	**MKUHFT**	Henry was transferred from University Hospitals Coventry and Warwickshire to MKUHFT. Noted as Henry's first attendance at MKUHFT.	Henry returned intubated and ventilated. Being treated for a hospital acquired pneumonia.
Early April 2019	**MK GP Surgery**	Heidi attended medical centre for review with her GP after being discharged from the hospital. Was very anxious about what was going to happen both to her husband and	Referral to talk for change for therapy

		her son. No previous mental health problems.	
Early April 2019	**MKUHFT**	Heidi - Visited her husband Henry in MKUHFT following transfer from Coventry.	Heidi was also a patient at Coventry Hospital and had been discharged.
Early April 2019	**MKUHFT**	Henry remained unwell and End of Life pathway was discussed.	
Early April 2019	**MKUHFT**	Henry transferred to ward 18 for End of Life Care.	
(date removed) 9.50am	**MKUHFT**	Henry died peacefully in hospital.	

2. The Facts

2.1. The Death of Henry

2.1.1 The events leading up to the death of Henry commenced on a Friday in March 2019 at 3.03pm when a neighbour called the Police and reported that Glen was smashing his house up, shouting and screaming whilst in possession of an air rifle. Following interactions with the Police and the Campbell Centre[16] over a period of 48 hours (detailed in the paragraph below), Heidi attended the Police Station to act as Glen's Appropriate Adult whilst he was detained in custody for the offences of Assault on an Emergency Worker (i.e. assault on Police) and Racially/Religiously Aggravated Public Order offences. Glen and Heidi were subsequently taken home in a Police van with Glen being placed alone in the rear prisoner 'cage' area. The rationale for this decision is unclear; the Police Misconduct Investigation Report (paragraph 9.4.4f) states *'…it appears that the decision to transport [Glen] in a police van, following his release, was taken purely out of safety concerns and due to the fact that he carried out a dirty protest when in his cell and officers concluded that the van was the most appropriate means of transport'.* Heidi sat with the Police Officer at the front observing Glen through a Perspex screen. Glen and Heidi were dropped outside the family home (Heidi and Henry's address) and not Glen's own nearby address.

2.1.2 Earlier in the day a neighbour took Heidi to the Police Station as Henry was too unwell to drive her there. On Heidi's arrival, Glen was sitting with his legal representative. Heidi describes Glen as being unwell, agitated and difficult to engage with at the Police Station and she had not seen him like this before. Heidi informed the DHR Reviewers that she advised Glen's lawyer that she was not happy to take Glen home. It appears the lawyer also had difficulty engaging with Glen. In addition, Kim was deeply concerned that Heidi was called to act as the appropriate adult for Glen's interview at the Police Station. In Kim's view, which is understandable, a mental health professional would have been more suitable to perform the role of Appropriate Adult. The Police and Criminal Evidence Act (PACE) 1984 Codes of Practice does not

[16] The Campbell Centre in Milton Keynes is a 38-bed acute in patient mental health unit. It has two wards (Hazel and Willow Wards) predominantly for working age adults who require a hospital admission when suffering from a mental health problem. The wards are staffed 24 hours a day. Access via www.cnwl.nhs.uk/services/mental-health-services

specifically stipulate that a mental health professional should perform the role (see *Code C Detention, treatment and questioning of persons by Police Officers).*[17]

2.1.3 Heidi states that she felt ignored by the two Police Officers transporting them home. She recalls Glen being placed into the cage at the back of the van whilst she sat in the front with a Police Officer. Heidi maintained her concern for her son and apparently informed the Police Officer that she was worried sick that Glen was 'not right'. Glen meanwhile continued to talk and shake. On arrival at her home address Heidi states that they were dropped off at the front gate and left to walk quietly up the drive in silence. Once in the house, Heidi remembers Henry smoking in the corner, and informing them that she would change her clothes and then make coffee before cooking dinner. She saw Henry giving Glen a roll up cigarette before going upstairs to change her clothes. On returning downstairs she found her husband Henry lying on the floor injured and bleeding. She asked Glen what he had done and turned to call the ambulance service. Once she had made the call she passed out. Heidi had also been attacked leaving her with very serious injuries.

2.1.4 Glen was released from Police custody at 12.19pm. At 12.46pm and shortly after dropping Glen and his mother home, Police were called to the address by South Central Ambulance Service (SCAS), reporting they were responding to an incident of an elderly male and female having been attacked by their son. Glen was found close to the address and was arrested on suspicion of their attempted murder.

2.1.5 Henry was flown to University Hospital Coventry and Warwickshire (UHCW) by air ambulance with serious injuries, whilst Heidi, who also sustained serious injuries, was taken to the same hospital by land ambulance.

2.1.6 Heidi was subsequently discharged from hospital, whilst Henry had been admitted to intensive care to continue with his treatment at UHCW until he was transferred by land ambulance to MKUHFT in April 2019.

[17] Home Office, CODE C, Revised Code of Practice for the detention, treatment and questioning of persons by Police Officers accessed via https://www.gov.uk/government/publications/pace-code-c-2019

2.1.7 The Panel had sight of evidence from MKUHFT, which provides useful background in relation to Henry's physical and mental health prior to the assault. The evidence indicates Henry had *'chronic obstructive pulmonary disease with limited mobility due to this disease. He was a heavy smoker and also suffers Post-Traumatic Syndrome after military combat earlier in his life. He had a titanium plate in his head after an injury sustained during the Korean War. Due to weight loss and a chronic cough he had been referred to oncology for investigations to see if he had any underlying cancer causing these symptoms. He had an appointment with the colorectal team at beginning of April 2019 but at the time he was admitted to the intensive care unit at University College Coventry and could therefore not attend the appointment. He also had chronic back pain. Henry was a very frail man'.*

2.1.8 The UHCW Deputy Chief Medical Officer Report provided the Panel with some detail regarding Henry's treatment. The Report states '*Prior to Henry's transfer to the General Critical Care Unit at UHCW he was intubated by the hospital crew to support his breathing. We concluded from our investigation that when the endotracheal tube was cut in the Critical Care Unit (to be shortened), the suction tubing was also cut accidently as it had not been withdrawn fully into the protected sheath.'*

2.1.9 Henry succumbed to his injuries and sadly died in hospital in April 2019.

2.2 Sentencing of Glen

2.2.1 In mid-August 2019 Glen pleaded guilty to Manslaughter on the grounds of diminished responsibility and guilty to the attempted murder of his mother Heidi. Psychiatrists agreed that Glen was suffering from schizoaffective disorder and he was sentenced under section 37 of the Mental Health Act 1983 (an Hospital Order) with Section 41 special restrictions that are 'without a time limit'.

2.2.2 Mr Justice Edis on sentencing said:

> *"These offences occurred on the afternoon of March xx 2019 just after you had been released from police custody and at a time when you were behaving in an increasingly bizarre way."*

"….. your mother was becoming understandably very concerned about your behaviour but she did not feel at risk until you took a knife in the house and attacked both of them."

"From what you said soon afterwards, so far as it made sense, you clearly intended to kill both of them. And, as is apparent, you succeeded in the case of your father and you have no doubt left your mother in a desperately pitiful position."

2.2.3 Glen also pleaded guilty to assaulting an emergency worker and three charges of racially aggravated public order, which took place in March 2019. The judge commented that they were "serious, nasty offences of their kind".

2.3 Family History

2.3.1 Henry died on a Sunday in April 2019, at the age of 86. He had been married to Heidi for 54 years and had two children namely his daughter Kim and his son Glen, the perpetrator. Henry was well known and lived in the Thames Valley Area for 50 years. He had worked for a car manufacturer. Outside of work Henry was a very successful darts and bowls player for local teams.

2.3.2 Henry was a good friend of his neighbour Mick. Mick has confirmed that they used to play darts together at the British Legion. Alongside Mick, other neighbours have also said that Henry was a kind, quiet person with a dry sense of humour. He kept himself to himself and would not go out often. He loved his garden and spent time maintaining it.

2.4 The Perpetrator

2.4.1 Glen was aged 47 years of age at the time of the incident. Kim informed us that Glen is dyslexic and struggled at school, which he left in 1989 with no formal qualifications. That said, Glen was skilled with his hands, which he used creatively in his garden landscaping business. He had also previously worked in pest control and in road maintenance businesses.

2.4.2 Supported by the Level III Mental Health Reviewer a DHR Reviewer met with Glen in November 2019 and obtained information regarding his medical history, his family,

social background and relationships and the events surrounding the tragic incident. This meeting took place with his consent and the statutory Review process was explained to him.

2.4.3 Glen apparently liked the area of Thames Valley where he lived and where he went to school. Glen left school in 1989 by which time he was smoking cannabis. He started to drink heavily and take cocaine, which was exacerbated with the decline of his business, an accumulation of business debts and in 2004 the breakdown of an intimate partner relationship.

a. Relevant health

2.4.4 Glen stated that after his first inpatient stay at the Campbell Centre in 2016 that he was supported by his GP. He said he had a psychosis but did not know what caused it. He was informed that he had a non-organic drug induced psychosis. However, he stated that he had not apparently used illicit drugs for eight days in 2016 prior to this. That said, Glen outlined that his habit was to use half a gram of cocaine (a class A controlled drug) 4-5 times a week. He intimated, however, that he did not take 'speed'[18]; stating he did not like it as it gave him heart palpitations. Glen recalled that he last took amphetamines in 2005.[19] During interview Glen stated that he was puzzled that his blood test at the Campbell Centre showed traces of cocaine, speed and TCA (or Tricyclic Anti-Depressant).[20] He further stated that he had not taken "Coke" cocaine (or anything else, including cannabis) for eight days prior to this. Glen believes it was a false test and described the result as "mind boggling" for him.

[18] Speed is a reference to Amphetamine. See https://www.drugwise.org.uk/amphetamines/ Amphetamines in their powder form are Class B Drugs controlled by the Misuse of Drugs Act 1971. MDMA (Ecstasy) and Methamphetamine are Class A Controlled Drugs

[19] Description of Amphetamines is found here: https://www.psychemedics.com/amphetamine/

[20] For more information regarding TCA see https://www.healthline.com/health/depression/tricyclic-antidepressants-tcas

2.4.5 Glen described how, at the Campbell Centre, he had been injected ‘three times and it turned [him] into a zombie’. Although he did not know what he was being injected with, it was most likely to be injections of a depot anti-psychotic. [21]

2.4.6 Glen shared that he had money worries prior to this first admission. His property sale was slow going through and he was short of money for nine months. He also needed the money to buy a new truck to get to work.

2.4.7 From Glen’s perspective he stated that he saw his GP in 2013 when he was depressed and informed him about his cocaine use. The GP, according to Glen, agreed to arrange a counsellor but this did not proceed as Glen was using cocaine at the time. Glen, however, did not believe that he had ever been referred to substance misuse services. After the admission to the Campbell Centre in 2016, Glen talked again to his GP about feeling depressed.

2.4.8 In addition, at this time in 2016, Glen recalls that he was supported by CNWL’s community services. He knew to call a named nurse from the Crisis and Home Treatment Team if things got bad and found this support to be “nice”. Glen used to see his named nurse quite often, the last occasion was four months before the events of March 2019. However, at the time that this episode started, Glen did not call the nurse as he did not believe there was any sign of psychosis.

2.4.9 Glen detailed that he had missed appointments with the Crisis and Home Treatment Team because he wanted to continue to take diazepam, which he was obtaining on repeat prescription without attendance at his GP. It transpires that the Home Treatment Team had placed him on a high dose venlafaxine and did not know that Glen had been prescribed diazepam.[22] The venlafaxine helped to `pick [him] up’ and Glen felt that there was nothing more that the Home Treatment Team could have done as he was not talking to them. Glen stated that there was “no way of them knowing what was in [his] mind”. Glen’s account indicates a lack of communication between the

[21] For description of a depot see https://www.mind.org.uk/information-support/drugs-and-treatments/antipsychotics/depot-injections/

[22] Venlaflaxine is a type of antidepressant often used to treat depression. It is also sometimes used to treat anxiety and panic attacks. Diazepam belongs to a group of medicines called benzodiazepines. It's used to treat anxiety, muscle spasms and fits (seizures)

GP and the Home Treatment Team; particularly the prescription for diazepam that Glen was obtaining without face-to-face review.

b. Family, social background and relationships

2.4.10 Glen lived on the same residential street as his parents and saw them most days for dinner. Aside from this Glen preferred his own company.

2.4.11 Glen stayed with his sibling Kim during the week for three months from February 2016 working on gardening/landscaping to support him to get back to work. Glen returned to his own home at the weekends. Henry would sometimes go over to Glen's house so they could watch football together. In the summer of 2018 Henry and Glen also worked together to fix an elderly neighbour's fence.

2.4.12 At the time of the incident Glen lived alone, having split up from his last known intimate partner in 2004.

2.4.13 Glen used to go fishing and hunting, which he last did in 2014. More recently, Glen details being very isolated, lonely and suffered from low moods. He had not talked to anyone about his mood and was socially isolated. Glen by his own admission would spend most evenings at home alone with a bottle of wine and apparently taking cocaine.

2.4.14 A number of witnesses to the Review identified that Glen had money worries and following the sale of his house he apparently spent all of the proceeds and relied on his mother Heidi to pay his mortgage, which she did from 2014.

2.4.15 Prior to the incident, Glen explained to the Review that Henry had not been well; that he had cancer and described how he was "…. getting thinner and thinner…. He was wasting away and not eating." Glen said Heidi was worried sick about Henry, resulting in Glen worrying about her. Glen described his mother as being at her wits end and that she had always been a worrier. He also mentioned that Heidi's sister, his aunt, was dying because of old age. There has been no evidence presented to the Panel to date that Henry had been diagnosed with cancer.

2.4.16 In spite of her 40 years of nursing background Heidi mentioned that she did not see the ‘red flags’ of Glen’s deteriorating behaviour. Whilst his parents saw Glen most days, Heidi stated that she respected his privacy as an independent adult. She revealed that she was not aware that Glen was missing appointments with Compass and had stopped taking his medication. Heidi describes an occasion when she destroyed what she thought were cannabis plants that Glen was growing at his home.

2.4.17 Glen’s family confirmed that he did not excel academically, that he used to misbehave in school and get into trouble. Glen left school at the age of 16. As an 18-year-old, Glen had facial plastic surgery because he was self-conscious about his appearance.

2.4.18 Heidi informed the DHR Reviewers that Glen often spent time in the fields local to his home, where he would shoot rabbits. He was a good landscape gardener and helped Heidi and his neighbours with gardening. This is consistent with Glen’s role as a professional gardener.

2.4.19 Glen is described by Heidi and his friend on the one hand as being trusting and on the other by a former intimate partner as controlling and jealous. There were five major events it is believed by family, friends, and Glen’s former partner which contributed to the decline in his mental health and his consumption of illicit drugs and alcohol. We cannot of course judge the cause of, and the effect of, Glen’s mental ill health upon these events. We can only speculate about the causality. These events were:

Event 1 - Glen was fitting artificial grass and invested £25,000 with people in Scandinavia, Norway or Sweden. Glen lost all this investment and as a result lost trust in people.

Event 2 - Glen used to hire mechanical diggers from a company in Milton Keynes. Problems commenced when it is alleged that someone fraudulently signed his name to hire equipment, resulting in a Civil Court case against him for the recovery of what was described as thousands of pounds.

Event 3 - Glen had a previous property, which he tried to sell due to 'problems' with his neighbours. The house sale fell through three times and dragged on for 18 – 24 months causing distress. Glen finally sold the house and was happy as he needed the money to pay off a second mortgage. It is of note, however, that following his conviction, Kim acting with Power of Attorney (for land and property) discovered that this was not the case as she found correspondence highlighting default on payments and re-possession action by the mortgage company. Kim states that this is significant as she believed that the issue of debt played a major role in Glen's mental health crisis in 2016 and 2019.

Event 4 - An employee of Glen's (who was described as his 'right-hand man') left the business. Glen had supported this staff member several times with his gambling problem. As a consequence, Glen felt let down due to his previous experience (as outlined in event 1).

Event 5 - Five years prior to the index critical incident, Glen was driving his pickup truck when a wheel apparently came off causing a collision with five – six other cars. He was en route to an early morning job. Glen drove to the job and on his return to the scene the Police were called. His insurance company did not initially support his claim and the owners of the cars he collided with made private claims against him. Whilst the insurance company did eventually pay out, the drawn-out process had a negative effect upon Glen.

2.4.20 The Consolidated Chronology details instances of Glen's threatening and violent behaviour following an incident outside a public house and also poor behaviour towards a neighbour at a property he shared with his former partner Diana. It appears that Glen's behaviour towards the neighbours deteriorated after his partner left the relationship and their home, resulting in Glen subsequently being excluded by a Court Order from the property.

2.4.21 More recently in March 2019 Glen's behaviour, which included shouting, screaming and smashing window(s) at his home whilst wandering around his garden with an air rifle prompted a neighbour to call the Police two days before the tragic event, indicating a deterioration in his behaviour. During this event and whilst the police were in attendance, Glen attempted to swallow a quantity of tablets, which resulted in a

struggle with the Officers who restrained and detained him. He was subsequently detained under section 136 Mental Health Act 1983.

2.4.22 Glen has had one serious intimate relationship that we are aware of, which ended in 2004 following the change in his behaviour after moving into a joint home in 2002. Diana states that Glen was 'amazing' when she first met him and that his bizarre behaviour commenced as soon as they moved into their shared home.

2.4.23 Diana, the former partner told the DHR Reviewers that when buying food Glen would use two fridges. He had a separate fridge for himself and his cats. He would buy the cats fresh food and they ate better food than Diana and her young son. Glen kept buying her son cans of food to eat. Diana said that it appeared to her that Glen did not understand why she and him should eat together with her son as a family and Glen wanting the youngster to eat by himself. Apparently, Glen would hide the things Diana's son left around and would, for example, throw her son's shoes into the garden even in the rain if he left them in the wrong place in the house. Diana described Glen as controlling and jealous towards her son, which left him feeling worthless. When challenged by Diana, Glen would apparently state that that was how he was treated.

2.4.24 Glen became very possessive of Diana and very jealous of any time she had with her son. For example, if she was trying to do homework with her son, Glen would put on loud music or start banging around the house until her son was asleep. Glen even stopped Diana putting heating on in the winter and there would be arguments over the thermostat controlling room temperature.

2.4.25 The final straw for Diana in the deteriorating relationship was when it was Diana's brother's 40th birthday party. Glen declined to attend and Diana attended with her son. Whilst at the party Diana received abusive texts from Glen using foul language to describe her son. Glen was rummaging around her son's room and found a notepad in which her son had been writing down his feelings. The youngster had written a letter to Diana about Glen asking Glen to be nicer to him and more fatherly, begging him to be the person he had been before. Glen was upset by this and when confronted about his behaviour by Diana, he had refused to tell the child that everything would be ok. Realising that Glen had discovered the letter, Diana's son had a panic attack and was

sick on the driveway outside their home on their return from the family celebration. This was a turning point in Diana's relationship with Glen. She left the home with her son, leaving Glen.

2.4.26 The Wednesday before Glen attacked Henry and Heidi, Diana thought there was a problem as Glen was commenting on her photograph on Facebook and had started to post songs that they had liked together. The day that Glen attacked his parents Diana stated that she instinctively knew it involved Glen when she heard about the attack.

c. The tragic incident

2.4.27 On the day of the incident, Glen informed the DHR Reviewers that he had been on Facebook updating his profile focusing on what he called `the evolution of Glen'. Glen said he had two guns and he threw them across the garden, which was seen by his neighbours. He then went on to smash one of the windows at his home. However, he did not initially remember being taken into custody. He said he was not hearing voices at the time.

2.4.28 Glen recalled being arrested for breaking a window at his house. The Police took him to the Campbell Centre, but they would not let him stay and he didn't know why. Glen was then taken to the Whiteleaf Centre in Aylesbury where he waited for two hours whilst they discussed what would happen to him. His recollection at this point does not accord with the Consolidated Chronology as he was conveyed to the Whiteleaf Centre after being charged by the Police.

2.4.29 Glen recalls being taken into Police custody, being locked up at the Police Station, and then released the following morning. He apparently recalls being at MKUHFT where he was abusive. Glen states that he does not remember much about that day because he had taken cocaine in the morning, which he believed would not hurt him. He went on to say that he had not been himself because of using "coke every day for nine months". Glen stated he was `not being psychotic', however, he had "not felt like that before". He went on to say that he did not normally feel angry on drugs.

2.4.30 During an interview Glen stated that he was worried about his mum who "worries about everything", that his dad was dying and that Glen himself was ill. Glen detailed

when he went to get the knife to kill himself, but he knew this would destroy his mum if he did this, so he thought he would kill them (his parents) instead.

2.4.31 Glen stated that he knew about the signs of psychosis and will experience a euphoric feeling when he is psychotic. He imagined the sky like thunder with streaks coming down and spikes above it; he saw the spikes coming down. Glen also gets a vision and can smell something. He cannot describe the smell. When psychotic, he felt frustrated and his mood would be `hyper' or `high' but sometimes very low.

2.5 The Police

2.5.1 Thames Valley Police (TVP) had no contact with Henry or Heidi other than in connection with their son Glen. There is no record of contact with Henry, Heidi or Glen with any other Police Force.

2.5.2 TVP's first recorded contact with Glen was in 2000 following an arrest for assaulting a male with a wooden bat. Glen was charged with Actual Bodily Harm and possession of an Offensive Weapon. He was apparently not convicted of these offences. The Panel sought to obtain records relating to this incident but the Police do not have retrievable records on this matter.

2.5.3 The next recorded contact with TVP involving Glen was from later in June 2006 following a series of harassment incidents reported by his neighbour. This behaviour reported by Glen's neighbour Nancy included noise disturbance, throwing dead birds over the fence, barking loudly like a dog, verbal abuse and filming his neighbours from his garden. Following his arrest Glen was given a fixed penalty notice for disorderly conduct. The behaviour, however, persisted and deeply affected and disrupted Nancy's family life. Glen was given an Harassment Warning Letter and TVP has since acknowledged that this was not the correct course of action in light of the earlier fixed penalty notice. The incidents persisted and Glen was further arrested and charged and in March 2007 he was convicted of harassment whereby he was ordered to pay a fine and compensation. No mental health problems were identified and recorded by the Police, nor was a referral to support agencies made by any of the public authorities involved with this particular incident and subsequent conviction.

2.5.4 The next relevant period of Glen's contact with TVP began at the beginning of June 2016. There were five incidents recorded by the Police over a period of eight days between –in a one-week period in early June 2016. This began when Glen called the Police asking for attendance at his home address. He was described as being incoherent. Police attended and found Glen behaving irrationally and communicating with them using paper. Glen had apparently believed someone had broken into his home but the Police could find no evidence of this. Heidi attended the address as did the Mental Health Street Triage Team who were called by the Police. It appears that on this occasion Glen did not meet the criteria for an intervention and was taken to his parent's address nearby where he calmed down significantly. He revealed that he had been drinking whilst taking his medication for depression and that he was intolerant to sugar, although this latter aspect was not medically determined. The Mental Health Street Triage Team advised Glen to see his GP and he was provided with the Urgent Care contact number. The attending Police Officer completed an Adult Protection Report and this was subsequently reviewed by the Multi-Agency Safeguarding Hub (MASH) at the beginning of June 2016. The MASH acknowledged that no separate referral was made to Mental Health Services as Glen was already known to them and that the Mental Health Street Triage Team had been in attendance at the incident. Similarly, the Police Adult Protection Report was not communicated to Mental Health Services. It is of note that in the days following this Glen was admitted to the Campbell Centre; an acute inpatient mental health unit.

2.5.5 Three days later in June 2016 at 7.23pm Heidi called the Police stating Glen had discharged himself from hospital that day and was running around the street. The Police attended and noted that Glen's home had been smashed up and were advised by Heidi that he had come off his depression medication and had been drinking apparently resulting in paranoia. The Mental Health Street Triage Team was called but were engaged elsewhere. The Police Officer was concerned enough for Glen's welfare and requested an ambulance. It appears however that the ambulance was subsequently cancelled and Glen voluntarily accompanied the Police and the Mental Health Street Triage Team to the Campbell Centre where he was admitted.

2.5.6 The following day (in June 2016) at 5.22pm Heidi contacted the Police from outside the Campbell Centre where she and her husband Henry found Glen in an agitated state. They had come to visit him but he had discharged himself at 3.00pm. Glen was agitated and was refusing to accept water from anyone stating that it had been poisoned. Heidi informed the Police that she and Henry did not feel able to help Glen as they were elderly. This cry for support by Heidi and Henry appeared to have gone un-registered. Police records show that this incident was not deemed suitable for their attendance and SCAS were called to attend at 5.53pm together with the security at the Campbell Centre. At 6.48pm hospital security advised that Glen was 'flinging out' at anyone who came close. The SCAS had not dispatched a unit to attend the incident at that time and therefore a Police Unit was allocated to attend. The Police arrived 15 minutes later as did an ambulance. Glen was detained under section 136 Mental Health Act 1983 for an assessment at the Campbell Centre and was re-admitted. The Police Officers in attendance completed the appropriate section 136 incident report on the Police Niche system. Whilst Glen did not live in the same house as Heidi and Henry, they nevertheless maintained care for him and Heidi's overt request for support as an elderly carer had gone unnoticed. CNWL indicate, however, that discussions relating to Glen's care took place on two days in early August 2016 whilst Glen was in the Campbell Centre. A carer's session was offered to Heidi and Henry but it is unclear if this was taken up or if there was any reinforcement or follow up of the original offer.

2.5.7 In early June 2016 Police were called to Glen's home address by a neighbour concerned that he was going in and out of his house waving his arms around and was also seen on the roof a few days earlier. There is no information to suggest that the incident on the roof involving Glen was an attempt to self-harm. The Police attended with a Mental Health Street Triage nurse and Glen engaged with them. Heidi informed them that she believed Glen had taken cocaine. Records from the Campbell Centre revealed that he had been discharged at midday and that his behaviour was drug induced and not due to his mental health. On this occasion no further action was taken by the Police as the triage nurse concluded that Glen did not meet the threshold for detention under the Mental Health Act. The attending Police Officer did not complete the Adult Protection Report and TVP have acknowledged that this is an area for improvement. In the circumstances an Adult Protection Form should have been completed, a referral made to the MASH and disseminated to Mental Health Services

and the Compass Team to inform their decision-making regarding interventions. The Police acknowledged that this was a repeating problem, which has since been addressed through updated operational guidance and enhanced safeguarding training for all Police Officers. Of note, an Adult Protection report would have created a searchable record of the incident for Police information purposes and would be available to frontline officers 24/7.

2.5.8 A day later in June 2016 at 10.15am, Heidi called the Police to report that Glen was high on cocaine, was uncontrollable and was damaging his house. There are no further details of this call or the Police response because of the way linked calls are archived by the Police. The Police have recognised that this is a problem and a future new contact management system will overcome it from the construction of the new technology package but will not enable retrospective checks.

2.5.9 The Police received a further call at 12.45pm the same day from a member of the public who reported that a man was kicking over traffic cones near the town centre, was behaving erratically and had nearly got run over. The call was identified as being linked to an earlier report at 10.15am the same day. Police attended on receipt of further reports of a man, who was subsequently identified as Glen running into a pub and hugging and licking people's faces before running out again. Officers attended and detained him describing him as erratic and incoherent. Glen lashed out at the officers and was restrained using handcuffs and leg restraints. He was detained under section 136 of Mental Health Act (MHA) and an ambulance was requested at 1.00pm by the Police and arrived approximately 60 minutes later. Glen was taken to MKUHFT's Accident and Emergency (A and E) in the first instance and was described as biting, spitting and thrashing around in the cubicle. He was discharged from A and E at 4.18pm to the Campbell Centre on the same site. The Police, however, have reported that there was an expected four hours wait for an ambulance to undertake the transfer. Accordingly, the TVP Duty Sergeant decided that it would be in Glen's best interest to be driven to the Centre by Police Officers whereupon he was then left in the care of staff. A section 136 MHA Report was completed by the attending Police Officers. TVP acknowledge the issues around delays in suitable transport and conclude that whilst these were the right decisions in the circumstances, they were against policy.

2.5.10 The Police had no further contact with Glen until the incident in March 2019.

2.5.11 On the Friday in March 2019 at 3.03pm a neighbour called the Police and reported that Glen was smashing his house up, shouting and screaming. Glen had also been seen to throw an air rifle down the side of the house and had been trying to smash windows. Three single-crewed Police Officers arrived at the location at 3.13pm and noted considerable damage to the three-bedroom detached house. Windows were smashed and a curtain and pole were hanging out of an upstairs window; kitchen knives were strewn around the garden. The house, particularly the kitchen, was in an untidy and dirty state. Glen was identified in the street and presented with a number of small cuts to his arms and a hand. He was in an agitated state and told Police Officers that he was suffering from a psychotic episode, having recently taken cocaine and cannabis. He was racist towards an Asian Muslim Police Officer engaging with him that he wanted to rid the world of Islam. The officer requested the attendance of the Mental Health Street Triage worker to attend but was informed that they were not yet available and were at the Campbell Centre. One of the Police Officers tried to make contact via the urgent advice line number but the line was engaged. Glen returned to his home and the Police Officers followed him. Glen picked up a packet of tablets and quickly began to put them into his mouth. The Police Officer grabbed him as he continued to take further ‘tablets’ and restrained him using handcuffs. The Police Officer recorded this use of force was necessary for both their safety. Given the background to the incident the Police called an ambulance. Whilst waiting for the ambulance Glen’s behaviour deteriorated whereby he was making inappropriate comments including further derogatory and discriminatory remarks about Islam. He then threw himself across the lounge and was again restrained on the floor for his own safety.

2.5.12 At 4.00pm the ambulance arrived and Glen’s parents were alerted to what was happening. Whilst being transported to MKUHFT he kicked a male officer with both his legs, and as a result he was placed in leg restraints. On arrival at A and E Glen was shouting racially and sexually abusive language at a passer-by and was therefore arrested for Racially Aggravated Public Order and Assault on Police.

2.5.13 At MKUHFT whilst Glen awaited to be medically assessed, he was under Police guard. The duty of Glen’s “bed watch” was handed over to four consecutive pairs of

Police Officers, each time with a verbal handover of earlier events.[23] As Glen became calmer, the positioning of the leg restraints and handcuffs were adjusted for his greater comfort. At 6.47pm a Police Officer recorded that he had spoken with Glen's brother-in-law (Igor) who had attended the hospital to enquire about Glen's welfare and offer his assistance. Igor stated that he would be the point of contact for the family. Igor's details were recorded in the Police Officer's notebook.

2.5.14 Later that evening Glen was medically discharged, although it is unclear from Police records exactly when that was as he was moved to another part of the hospital to await a Mental Health Act Assessment (MHAA). This assessment was due to take place in the morning. It is clear that had a document similar to the TVP PAC 41G been completed, the details concerning the movement of Glen would have been more precise.

2.5.15 At 8.28am the following morning a Special Constable was undertaking Glen's 'bed watch' and called for assistance on her radio. Whilst on a cigarette break Glen attempted to 'suddenly move away' from the officer resulting in her grabbing him at which point he fell to the ground and had to be restrained pending the arrival of other officers.

2.5.16 It was unclear when the MHAA at the hospital would take place and a Police Officer in attendance formed the view that Glen's behaviour was unpredictable, disturbing other sick patients and that he could not be safely detained in that environment. The Police decided that Glen was to be transported to custody to enable the MHAA to be undertaken. TVP's view was that the Police Officer's actions were appropriate given the fact that Glen was under arrest for criminal offences. Glen's assessment would have occurred quicker, the Police assert, had he remained at hospital. Police contend however that the outcome of the assessment would have been the same and therefore not impacted the eventual decision to release Glen from custody.

[23] Bed Watch is the phrase used to describe police officers who are guarding and providing security to a detained person at hospital

2.5.17 On arrival at the Police custody centre (at 9.28am) it was identified that Glen had defecated, and he was offered the opportunity to shower and change, which he took. The duty Health Care Professional (HCP) in attendance assessed Glen and advised that he required a Mental Health Act Assessment. An ambulance was arranged and Glen left custody for the Campbell Centre at approximately 11.00am.

2.5.18 At 12.15pm the Detention Log PAC41G details that Glen was waiting in the section 136 suite at the Campbell Centre, where he was given a meal and conversed with Police Officers. The Detention Log also states, according to the Police, that Glen's behaviour began to deteriorate. He was assessed by the Approved Mental Health Practitioner(s) and clinicians at 3.15pm and was "declared fit by the doctors" according to the entry in the Detention Log. The Panel considered whether the assessing clinicians would have had direct access to Glen's medical history. He was then conveyed to the Police Station.[24] The custody record details that on Glen's return [the] "Doctor refused to provide any documentation." It is vital that when a Police detainee returns to Police custody/detention after receiving medical treatment that the Custody Sergeant is effectively appraised of their condition so that they can properly discharge their duties to ensure the detainee is afforded their rights and treatment in accordance with the Police and Criminal Evidence Act (PACE) 1984.[25] In addition, such documentation is of similar importance for the custody / detention facility's HCP. The provision of such essential documentation is an area for improvement.

2.5.19 Glen was returned to the Police custody/detention facility where shortly afterwards it was reported that he had stripped naked, defecated on his cell floor and rubbed faeces onto his face. He was monitored on CCTV. The HCP in attendance raised concerns about Glen's continued disturbing behaviour with the Duty Mental Health Team who were visiting the custody facility to assess another detainee.

[24] The use of the phrase 'declared fit' has different agency interpretation and so adds to the learning about language and understanding of process

[25] The Custody Sergeant is a rotational role and manages the custody suite, including the care and welfare of detained persons and takes the decision to authorise or refuse the detention of any person presented before them. Ensures that while detainees are at the custody suite, police officers and police staff adhere to the Police and Criminal Evidence (PACE) Act 1984 Codes of Practice regarding the rights and treatment of persons arrested. For more information see https://profdev.college.police.uk/professional-profile/custody-sergeant/

However, the HCP recorded that the Duty Mental Health Team's opinion was that Glen's actions were "behavioural or drug induced" and did not wish to re-assess him or observe him on CCTV. This was also noted by Glen's solicitor. The HCP reported that Glen was fit to be detained but not fit for interview. The Custody Sergeant recorded that Glen would be put into a rest period as he had been advised that Glen was under the influence of drugs. A further assessment of Glen's fitness for interview was to take place in the morning. The Custody Sergeant was clearly concerned and sought the intervention of the Duty Mental Health Team who were visiting another detainee. Notwithstanding the Custody Sergeant's concerns, the duty Mental Health Team maintained a stance that Glen's actions were 'behavioural or drug induced'. The HCP in turn was also left with this advice.

2.5.20 On a Sunday in March 2019 the same Custody Sergeant and HCP who had dealt with Glen the previous day returned to work. The Custody Sergeant reported that Glen was calm and polite when he spoke to him to offer him a further shower and change of clothes. Glen was assessed as fit for interview by the HCP and required an Appropriate Adult for interview.[26] His mother Heidi was called by the Police and arrived at the Police Station to undertake this role at around 10.30am. She was deemed suitable; as being able to competently discharge the appropriate adult role by the Police. The Review Team has spoken to Glen's Solicitor Linda who describes Heidi as 'sprightly'. Glen entered a consultation room with Heidi and his solicitor and shortly afterwards Heidi left the room at the request of Glen according to Linda. After a few minutes Linda left the consultation room complaining that Glen was persistently passing wind and she felt she was unable to give Glen advice and take his instructions. In Linda's professional opinion, recognising that she is not a medical professional, Glen was not fit for interview. He also threw a cup of hot chocolate against the walls of the consultation room.

2.5.21 The lead Custody Sergeant for Glen's detention discussed his options with the other Custody Sergeant on duty, the Officer in the Case (OIC) and the PACE

[26] The aim of an Appropriate Adult is *"…to safeguard the rights, entitlements and welfare of juveniles and vulnerable persons to whom the provisions of this and any other Code of Practice apply".* **PACE Code C (revised July 2018) 1.7A**

Inspector.[27] Glen was coming towards the end of his 24-hour detention period permitted by the PACE Act 1984. The Police records highlight that the Custody Sergeant precluded a further MHAA as he felt that Glen's behaviour had not deteriorated since the last assessment less than 24 hours previously. The Custody Sergeant determined that even if the charging threshold had been met (and he recorded that it had not) an application to remand Glen in custody was not appropriate, based on the alleged offences and Glen's limited previous offending history. The Custody Sergeant recorded in Glen's custody record that he had discussed the threats, risks and harm associated with the case with the OIC and was satisfied that bail conditions would not be necessary or proportionate. He recorded that further safeguarding and control measures could be implemented by the OIC (presumably in part by submitting an adult protection form generating an onward referral to partner agency services, as the officer was reminded to complete such a form after Glen's release) and that the "presumption to release without bail shall apply", thus being released under investigation (RUI). It was decided that officers could then conclude their investigation, including obtaining a voluntary interview of Glen in accordance with the PACE Act 1984, at a later date when his mental state had improved.[28]

2.5.22 The Custody Sergeant's Pre-Release Risk Assessment was recorded as Level 2 (Raised) and Glen was provided with what is described as a *Useful Support Leaflet* alongside other controls, which are highlighted as part of the Pre-Release Risk Assessment including being:[29]

"Released in presence of his mother who was acting as app [appropriate] adult,

---

[27] The PACE Inspector is a rotational role responsible for the strategic management of the Custody suite and staff, ensuring the safety and security of all to enable the achievement of operational policing objectives for the duration of a shift. Proving all required authorities and ensuring that compliance with the Police and Criminal Evidence Act (PACE) Codes of Practice relating to the detention of suspects. For more information see https://profdev.college.police.uk/professional-profile/pace-inspector/

[28] A 'voluntary interview is an interview of a person suspected of a crime but is not under arrest. The interview is conducted under the auspices of the PACE ACT 1984 and the contents of the interview can be used in evidence.

[29] This relates to Pre-Release Risk Assessment level that the Custody Officer selects from a drop down list:
Level 1 (Standard) Pre Release Risk Assessment
Level 2 (Raised) Pre Release Risk Assessment
Level 3 (High) Pre Release Risk Assessment
Level 4 (Very High) Pre Release Risk Assessment

Solicitor also present.
OIC will provide DP (Detained Person) and his mother with a lift home,
Mother has been given advice to call police should DP's behaviour not improve where officers could attend and consider 136. I have explained DP may need to see his GP on Monday and try and get further support that way."

2.5.23 The Custody Sergeant reported in his statement that in his opinion there was nothing to suggest a risk that Glen might be violent towards himself or anyone else, especially his parents. The Panel noted, however, that there is some historic and more recent evidence of Glen using or threatening violence towards people and property most notably Police Officers. Whilst in the custody of the Police, due to violence or the threat of it, Glen had been placed in handcuffs and leg restraints. The Custody Sergeant further reported that he considered that being in the custody environment may have contributed to Glen's behaviour. He offered Glen the option of Police Officers taking him to the Campbell Centre as a voluntary patient, but Glen declined and said he wanted to go home. The decision was explained to Heidi and Glen's solicitor Linda, who made no representations against the decision. Linda agrees that the Police had no option at this stage but to release Glen from Police Detention under investigation. The Sergeant reported that Glen seemed to have a good rapport with his mother, who is a retired nurse with 40 years' experience, and he felt Heidi would be able to offer him support and see that he took his medication. It appears that the Custody Sergeant assumed that they were living in the same household. The Custody Sergeant could have implemented a decision to conduct a second MHAA, less than 24 hours after the first, and escalated the request if it had been resisted (as was done later following Glen's arrest for the grave attack upon his parents). However, with no clear deterioration noted in Glen's behaviour, the Custody Sergeant could have reasonably expected that a similar decision may have been made by the Mental Health Team.

2.5.24 The Custody Sergeant arranged for Glen and Heidi to have a lift home in a Police van. Glen was placed into the prisoner "caged" area at the rear behind a Perspex screen; Heidi and a Police Officer sat nearby. The Police Officers have described making 'small talk' with Glen on the way home and that he had remained calm, though made repeated comments about the risk of catching AIDS off the cage floor. The officers advised Heidi to contact the Police immediately if she had any concerns, whilst

they reported that they themselves had no concerns that Glen presented as a risk to his parents. They left after seeing Glen and his mother walk up the path to Heidi's house.

2.5.25 At 12.46pm that day, and shortly after dropping off Glen and Heidi, Police were called to Heidi and Henry's address by South Central Ambulance Service (SCAS), reporting that they were responding to an incident of an elderly male and female having been attacked by their son. Glen was found at the front of one of his parents' neighbour's properties and was arrested on suspicion of attempted murder.

2.5.26 On admission back into Police custody Glen reported having depression, anxiety and psychosis and stated that he had further mental health problems that were not diagnosed. Glen reported being cocaine dependent having used two days earlier, and that he wanted to kill himself. Glen was seen by a HCP (not the same individual as the day before) in custody who noted that Glen appeared delusional and thought disordered, requiring a MHAA. A referral was made to the duty AMHP at 3.20pm. At 6.00pm it was noted that the duty AMHP had called to advise that they would not be performing a MHAA; the justification given was that the civil pathway was not appropriate (based on the seriousness of the alleged offences) and Glen should be put before the court so that a decision could be made to assess him further within the criminal justice system. The custody HCP recorded that Glen was clearly unwell and needed an assessment and that the Custody Sergeant would be escalating the decision. At 9.53pm it was recorded that Glen would be going to the Campbell Centre for an assessment and that he would be transported in a Police van, not an ambulance based on his previous behaviour.

2.5.27 At 12.33am the next day (in late March 2019) the Police PACE Inspector noted *"I have liaised with the officers who are transporting the Detained Person to the Campbell Centre, the LPA's (Local Police Area) designated place of Safety for MH assessments. At this time they have been refused entry and staff have indicated they have been instructed to refuse entry and then stated their S.136 Suite is occupied anyway…. I have escalated the situation to the on call duty manager for MH services – 'CW' - who has refused to acknowledge the escalation procedure or that it is their*

responsibility to find an alternative place of safety." This was escalated to the Police PACE Superintendent[30] to liaise with the Director of MH Services.

2.5.28 The Police records reveal that while Glen was being transported to the hospital he had head-butted the cage of the Police van and injured his nose. He was examined for this injury by a medical professional in the van outside the hospital. The escalation process referred to in paragraph 2.5.26 resulted in Glen being taken to the Whiteleaf Centre in Aylesbury for the MHAA to be conducted. Glen was transported there by officers in a Police vehicle. Glen was returned to the Police Custody Centre following this assessment; he was not detained under the Mental Health Act 1983. The Police records indicate that the HCPs conducting the assessment were not able to fully explore Glen's mental state and did not want to discuss the specifics of the case. Glen was not a registered patient at the Whiteleaf Centre.

2.5.29 On the same date in March 2019 referred to in 2.5.27, Glen was deemed not fit for interview and after referral to the Crown Prosecution Service (CPS) he was charged at 6.36pm with two counts of attempted murder and later with Racially Aggravated Public Order offences and Assault on an Emergency Worker. He was remanded into the custody of HMP Woodhill and placed in the Healthcare Centre. In mid-April 2019 he was transferred to the hospital at Marlborough House, under Section 48/49 of the Mental Health Act 1983 due to the decline in his mental health and his erratic behaviour. Two Court designated Psychiatrists agreed that Glen was suffering a Schizo-Affective Disorder and he subsequently entered a plea of Manslaughter on the grounds of diminished responsibility.

2.6 Milton Keynes University Hospital Foundation Trust (MKUHFT)

2.6.1 Henry had only attended MKUHFT once in early July 2018 for a test relating to an un-related matter. A referral was also made by his GP in mid-March 2019 to the hospital for a two-week appointment related to a suspicion of cancer. This appointment did not proceed as Henry was being treated for his injuries received during the serious assault.

[30] The role of the Police PACE Superintendent can be found by visiting https://profdev.college.police.uk/professional-profile/1274/

2.6.2 Glen had attended MKUHFT previously and had two admissions during 2004 - 2010 following an un-related condition, which required inpatient admission for treatment. There was no reference made to any behaviours or dialogue, which gave cause for concern.

2.6.3 Glen attended the Accident and Emergency Department (A and E) in early June 2016 at 10.49am following a reported convulsion/seizure at his GP surgery. Glen left A and E before assessment by a doctor before 1.00pm. Glen returned later that day at 9.35pm accompanied by the Police and was presenting with mental health issues. He was assessed by the Mental Health Team and transferred to the Campbell Centre.

2.6.4 Glen's next attendance to MKUHFT A and E was four days later in June 2016 at 1.00pm when he was brought in by ambulance with Police under section 136 MHA.

2.6.5 Glen's next recorded attendance at MKUHFT A and E was in later March 2019 at 5.36pm when he was brought in by ambulance accompanied by the Police once again. He was alleged to been behaving strangely and aggressively after taking cocaine, cannabis and (20mg) Diazepam tablets. Glen remained in A and E for observation with a Police presence until the next morning. Hospital records show that it was recommended that Glen remain in the Observation Unit until A and E medical staff deemed Glen to be medically fit for assessment by the Mental Health Team. He was verbally aggressive and abusive throughout the observation period. Unfortunately, MKUHFT has no further documentation indicating what happened next regarding this assessment and its outcome. Record keeping is therefore an area of improvement.

2.6.6 No further attendances are recorded.

2.6.7 During Glen's attendances to MKUHFT there were no documented references to Glen's family members or any concerns about threats he was posing to them.

2.6.8 On attendance to MKUHFT in later March 2019 Glen was seen and assessed by the A and E doctor and referred to the Mental Health Team for assessment when fit. There is no documentation within Glen's medical notes at MKUHFT that confirms

whether the assessment by the Mental Health Liaison Team (MHLT) took place and the outcome. A and E has read only access to the community system called 'SystmOne'.

2.6.9 Glen returned to A and E with a Police escort just after midnight three days later in March 2019 with a nose injury, which he sustained when secured alone in the 'caged area' of the back of a Police van whilst he and his escort were waiting outside the Campbell Centre. Glen was apparently acting erratically whilst so detained, whereupon he struck his face on the seating area and sustained a cut to the bridge of his nose and he also complained of having difficulty in breathing. The Police report that he was examined by a nurse in the back of the van and was not taken into the hospital building.

2.6.10 On that date in March 2019 Glen did not return to MKUHFT. A decision for Glen to return to the Police station was made by an accompanying Police Officer. This attendance may have been an opportunity where further medical assessment and assessment of risk could have taken place.

2.6.11 MKUHFT has highlighted that the Mental Health Team is expected to record assessments and outcomes on MKUHFT eCare system. It is noted that no signs or signals relating to risk(s) were witnessed or identified in the disclosed written records. Glen was initially referred to the MHLT following attendance at MKUHFT for mental health/drug overdose. When Glen was an inpatient previously there was no evidence to suggest his manner or behaviours were a cause for concern nor were there any references to any verbal conversations implying a potential risk to family members or others.

2.7 General Practice (GP)

Henry

2.7.1 Henry was registered at a GP Practice (known to the Panel members) as a patient and received General Practitioner services from August 1991. He saw several health practitioners at the Medical Centre over the years for various health problems and remained a patient until his death in April 2019. In particular, Henry was seen by his GP Practice twelve times between January 2016 and April 2019. These were for medication

queries, minor illnesses and joint problems. Henry also had some weight loss and general weakness, which was being investigated at the time of his death.

Glen

2.7.2 Glen was assessed and diagnosed with depression in 2009 and was started on medication. He was also diagnosed around the same time with another medical condition, which is described as being a painful condition and seemed to contribute to his mental health problems at the time. In 2013 Glen admitted using cocaine and alcohol and was referred to the drug and alcohol service and the Mental Health Team. He was declined treatment by the Improving Access to Psychological Therapies Team (IAPT) and advised to have drug and alcohol counselling first as per their local policy.

2.7.3 Glen engaged with the MK GP Practice but did not interact with the drug and alcohol services when referred. He did not always allow full investigations of his problem and often missed appointments or did not wait to be fully treated, which is evidenced by missed telephone contact appointments.

2.7.4 The GP Practice had been treating Glen since 2009 for both his physical health condition (referred to above) and also his mental health issues. GP information confirms that he did comply with taking medication but often felt they were ineffective at which point they were changed. But it is very likely, according to the GP, that the medications were ineffective due to Glen's concomitant drug and alcohol use. Glen did not attend for Drug and Alcohol Counselling when referred. The GP Practice acknowledge that there could have been more encouragement and follow up by his GP to try and motivate Glen to attend.

2.7.5 There is no indication from any previous history that Glen was a risk to family members. There had been no history of self-harm or violence to anyone. Heidi had been in touch with the GP to get advice when Glen was missing from home. The dynamic at home appeared to be one of caring parents genuinely concerned for their son according to the GP. The Panel acknowledged the difficulty that Henry and Heidi must have had trying to understand illicit drugs and their impact on Glen.

2.7.6 The GP had been involved with Glen's care and in supporting his parents especially Heidi. The GP had advised that Heidi should contact the Police when there were concerns of Glen being missing as well as referral to the involvement of the mental health and the drug and alcohol teams. The GP had made referrals and signposted to other agencies to support Glen's care but this was not always followed up.

2.7.7 There are no documented records of Henry and Heidi reporting any concerns about Glen being a threat to them. They were concerned about Glen's health and his ongoing drug use but there was no apparent mention of feeling threatened or at risk. From the GP's records, the GP did not consider the support Heidi and Henry may require in caring for their son. Heidi's call for assistance to the GP when Glen had gone missing could have been met with a referral to Adult Social Care and local support agencies for older people as carers.[31]

2.8 Milton Keynes Adult Substance Misuse Service (Compass)[32]

2.8.1 Compass was involved with Glen from initial assessment in early June 2016 until he was discharged in August 2016. During this period Compass staff only saw Glen on two occasions once for assessment the first date in June 2016, and then again to complete a risk assessment at the end of June 2016 at the Campbell Centre.

2.8.2 There were no other interactions with Glen due to him being sectioned and placed on a ward. Compass was, however, involved in professionals' meetings to plan for Glen's discharge from the Mental Health Ward.

2.8.3 Compass records detail evidence of unsuccessful phone contact with Glen to try to engage with him in mid-July 2016 (when Glen was in the Campbell Centre), in August 2016, and twice in September 2016. Calls were also made by Compass to the Campbell Centre to check on Glen's progress once in July 2016, and twice in August 2016.

2.8.4 Compass records also reveal an incident record was made by a Compass staff member after she attended the Campbell Centre to see Glen as follows:

[31] NHSE defines a carer as 'A carer is anybody who looks after a family member, partner or friend who needs help because of their illness, frailty or disability. All the care they give is unpaid'.

[32] This service has now changed. This service is now provided by CNWL for adults.

"XX/Jun/2016 [Glen] was sectioned 5 days ago so I attended the Campbell Centre to check how he is doing. I telephoned the ward in advance so that a nurse would be available to update me on [Glen's] situation.
When I attended the Campbell Centre, the nurse walked into the meeting room (which was actually a family room with toys on the floor) but didn't stay and locked me in the room alone with [Glen]. I had thought that he would stay in the room with us but he left without discussion. The security guard's room was next door so I positioned myself close to the door. [Glen] stated that the staff are putting thoughts into his head. I asked what the thoughts are and he repeated "big black cunts" around 30 times and also stated that they are making him want to grab me. I was very uncomfortable with the situation and knocked on the door for the security guard to let me out of the room. I could see him playing candy crush on the computer and he did not come to open the door until he had finished his level. He opened the door and then left the door unattended while he called for a nurse to take [Glen] back to his room. At this point [Glen] ran out of the room and then out of the building. Some Campbell Centre staff chased [Glen] and brought him back to the building.
I left at this point as they were dealing with [Glen]."

2.8.5 Following this incident, a Compass Manager held a discussion with team members about managing and preventing high risk situations with patients who are under section or mentally unwell on wards. Given the absence of information and record keeping it is unclear if the reported near miss risk incident from XX June 2016 detailed above was reported and discussed with the Campbell Centre. There was no feedback provided to the staff member who reported the near miss occurrence and her line manager is no longer working for Compass.

2.8.6 Following the above incident a decision was taken that no member of the Compass staff was permitted to see clients who were under MH section alone. In addition, it was determined that no member of staff should be locked in rooms with clients at any time and should there be a breach of this, a formal complaint could be made to a manager.

2.8.7 Compass records indicate that Heidi called them in late June 2016 stating she was worried about her son who was on the Mental Health ward. A staff member

reassured Heidi that she was on call and had made an appointment to visit him on the ward. It is unclear from records if this meeting took place. Certainly, whilst Glen was detained at the Campbell Centre this presented an ideal opportunity for the Compass Service to engage with him and encourage and motivate his engagement with the service. There was an undue reliance upon a telephone contact service.

2.8.8 There are no records that Compass holds that state Glen was a threat to his parents or that his parents felt he was a threat to them.

2.8.9 Compass assessed Glen's needs and communicated with the Campbell Centre to put a plan in place for his discharge. Glen did not turn up for any appointments with Compass once he was discharged from the Campbell Centre. Following the discharge planning meeting, which took place in mid-August 2016 where Glen's parents and sister Kim were present, Compass did not see Glen again.

2.9 Milton Keynes Adult Social Care

2.9.1 A referral was made by Henry to Milton Keynes Council's Community Occupational Therapy Team on a date later in March 2019. The request was for an assessment to be completed in relation to Henry being unable to get in and out of the bath. The Occupational Therapy Assistant who was initially allocated the case endeavoured to contact Henry twice in March 2019 and once in April 2019. It is therefore evident that Milton Keynes Council's Community Occupational Therapy or this specific staff member was not aware of the grave attack on Henry and his wife in March 2019 highlighting the lack of information sharing between departments within larger agencies such as the Council. This lack of information sharing between departments is an area for improvement.

2.10 CNWL

2.10.1 With the agreement of the Panel it was determined that CNWL's Serious Incident Investigation Report otherwise known as the Root Cause Analysis (RCA) Report would take the place of an IMR for the purposes of this Review.

2.10.2 CNWL has reviewed the records and information from the staff involved with Glen. The CNWL Reviewers were unable to identify a single root cause i.e. there was

no single delivery problem or contributory factor identified that had it not happened would have prevented the fatal incident. The CNWL Reviewers have identified one care and service delivery problem; however, it is not possible to say with certainty that it would have prevented the incident.

2.10.3 The CNWL Reviewers assessed the care and treatment delivered by their staff from June 2016 until the date of the incident with specific attention to the period from November 2018.

2.10.4 No safeguarding alerts were raised by CNWL as a result of the trigger incident. The CNWL Reviewers did not identify any safeguarding concerns in the course of their investigation, which involved interviews with staff post-incident.

2.10.5 CNWL identified the following practices have been identified as in keeping with expected policies/ procedures and local protocols:

- Risk assessments were completed in line with the Risk Assessment Policy at the allotted times during Glen's care: For instance on assessment, at admission and on discharge from the Campbell Centre and at Care Programme Approach reviews.
- Mental Capacity was assessed and recorded at the appropriate times during Glen's care pathway within services.
- Glen and his family were given a Crisis Card with contact details for out of hours' services.
- Glen was offered support regarding substance use when first known to services and this offer was repeated during his care, including at the Mental Health Act Assessment.
- Glen received full and comprehensive physical health care screening during his time with Early Intervention in Psychosis Team (EIPT) and when in the Campbell Centre.
- When assessed under the Mental Health Act the assessing team included a consultant psychiatrist who had had previous contact with Glen, another consultant psychiatrist who worked in Milton Keynes Mental Health services and two AMHPs – one of whom was representing the Acute Home Treatment Team.

2.10.6 On a date in late March 2019 Glen was taken to Police Custody from MKUHFT A and E at 9.20am due to concerns regarding his aggressive behaviour. At 11.15am Glen was placed on Section 136 and conveyed to the Campbell Centre where he was assessed in accordance with the MHA at 3.15pm by two doctors and two AMHPs to consider if hospital admission was necessary. The authors of the report have over 15 years AMHP experience and the consultant psychiatrist regularly assesses clients under the Mental Health Act in his role as consultant psychiatrist within the Hillingdon Rapid Response Team.

2.10.7 The CNWL Reviewers did not find evidence that Glen should have been statutorily detained at hospital as an outcome from the assessment.

2.10.8 The CNWL Reviewers noted that the AMHP organising the assessment contacted 'Dr E', the allocated consultant psychiatrist for Glen. 'Dr E' was not able to attend (it was a Saturday) but he provided feedback over the telephone to the AMHP regarding Glen. He highlighted Glen's recent recovery and well-being and stated that Glen had not been treated for psychosis for over a year but that EIPT were concentrating on working with him regarding his depression. There was also a plan to discharge Glen to his GP with support from Person Centred Planning. Dr E apparently registered surprise that Glen had damaged his property and had been arrested.

2.10.9 The NHSE Review indicates 'the psychiatrist asked for another duty doctor to be approached, a normal request in the circumstances. When Glen was seen, he did not show signs of aggression although his behaviour was socially inappropriate; he had tried to hug the nurses and he appeared excitable and overfamiliar'.

2.10.10 CNWL state that when arranging an assessment under the MHA it is preferable that one of the medical assessors should have previous acquaintance with the person being assessed. Dr M was then approached. He had previous acquaintance with Glen as he had been the treating consultant psychiatrist when Glen was an in-patient in 2016. The MHA details that efforts should be made to seek less restrictive alternatives to detention if it is safe and appropriate to do so, such as using an individual's own support networks, in line with the principle of care in the least restrictive environment.

2.10.11 The Acute Home Treatment Team were present at the assessment to provide an alternative support if the assessing team felt that was necessary.

2.10.12 Glen was interviewed in accordance with the Mental Health 1983 Code of Practice and his previous history was reviewed prior to the assessment. He was able to articulate his situation and describe that during a previous admission he had felt psychotic but that he was not currently psychotic. He admitted using both cannabis and cocaine immediately prior to this admission. He also stated that because of this he felt confused and had many thoughts in his head. The dangers of using drugs were described to him and that support was available for him regarding this – however Glen felt he did not need such support.

2.10.13 The two doctors assessing Glen agreed that he was suffering from the effects of using cocaine and stated, 'he was absolutely rational during the assessment'. Glen was assessed as having capacity; he was assessed as not being a risk to others or himself and was not presenting with psychotic symptoms. The CNWL notes indicate that Glen requested an admission to the Campbell Centre for a "few days rest". This was not investigated further.

2.10.14 However, the assessing team did not feel that there were "grounds for hospital admission".[33] Based on the medical records and the interviews with staff, the CNWL Reviewers agree with the outcome of the assessment undertaken.

2.11 South Central Ambulance Service (SCAS)

2.11.1 The South Central Ambulance Service (SCAS) had three previous interactions with Glen before the incident in March 2019. Glen was deemed by SCAS to lack capacity after the crew completed a Mental Capacity Assessment and he was taken to hospital with the Police. No safeguarding/welfare form was completed in March 2019.

[33] 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 Patient A 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.

There was no involvement from NHS 111 from January 2016 to date, four 999 calls to SCAS were noted.

2.11.2 In early June 2016 at 8.38pm the SCAS was called to Glen's home address. He was described by the Police as running around the street following discharge from MKUHFT and known to have mental ill-health issues. The ambulance was dispatched at 9.05pm. The SCAS notes indicate that Glen often sees things and thinks the Police are poisoning his mind. At 9.20pm the Police called back to cancel the ambulance as they would be taking Glen to the hospital.

2.11.3 A day later in June 2016 at 5.50pm SCAS was called to the Campbell Centre outside MKUHFT after the Police passed the call to them. Glen claimed that no one from the hospital was helping him and that he had discharged himself. The SCAS noted that Glen was claiming to be thirsty but not accepting help. His parents, Henry and Heidi who were in attendance could not control him. Police stated he was having a psychotic episode. The ambulance then arrived on the scene at 6.47pm. Records indicate that Glen had not been taking his medication for the last four days and had developed manic psychosis. He was assessed by the Campbell Centre staff overnight and self-discharged at 3.00pm. Glen failed a Mental Capacity Assessment conducted by the SCAS paramedic and was refusing to have basic observations done. The SCAS Crew attempted verbal coaching to transfer Glen to A and E, but he refused and wanted to go home. Accordingly, the Police were requested and arrived on scene and Glen was then detained under section 136 MHA and taken back into the Campbell Centre. He was in the care of the hospital by 7.55pm.

2.11.4 On a date later in March 2019 at 3.32pm the SCAS received a 999 call to attend Glen's home as he was "smashing up his house". An ambulance was dispatched and arrived on scene at 3.59pm. The presenting complaint was recorded as psychiatric or Mental Health Act and the history of the presenting complaint highlights that neighbours called SCAS as they heard Glen smashing up his house. Glen was found by Police walking down the road and stated that he was having a psychotic episode. The SCAS crew recorded past medical history as mental health and specifically psychosis. They

also recorded that Glen was an Illicit drug user of cocaine and cannabis.[34] Upon their arrival Glen who was with Police Officers was alert, had good colour and 'was in drink'.[35] Glen had smashed up his house after taking approximately 500mg of cocaine and cannabis and it was also believed he had taken 4 x 5mg of Diazepam tablets too. The SCAS records show that he was being verbally abusive at times. He had been handcuffed by Police for his own safety and informed the SCAS crew that he smashed up his house to make a point. Glen had a violent outburst in the ambulance, which resulted in him being arrested and Glen had to be restrained on the ambulance trolley. He was also using sexually explicit abusive language to the SCAS crew. On examination Glen denied any pain or other physical health problems and none were found. The plan was for the SCAS Crew to transport Glen to MKUHFT for further assessment and treatment. The SCAS Crew arrived at MKUHFT at 4.47pm and the handover of care took place at 6.38pm.

2.11.5 Two days later in March 2019 at 12.40pm the SCAS received a 999 call. Heidi was the caller who said that her son had attacked both her and her husband. An air ambulance was dispatched from Coventry and a second air ambulance was dispatched from Hinchinbrook. Henry and Heidi were both conveyed to University Hospital Coventry and Warwickshire (UHCW).

The Local Learning Review

2.12.1 The Local Learning Review referred to at paragraph 1.7.3 has continued alongside the DHR to identify learning and implement changes to multi-agency practice within the MK Together Safeguarding Partnership's service delivery arrangements at the earliest opportunity. The Local Learning Review Report has informed this Review. The MK Together Safeguarding Partnership is to be commended for recognising the need for and undertaking the Learning Review at the earliest opportunity to identify areas for improvement in the delivery of services.

2.12.2 The Local Learning Review indicates that prior to the incident Glen had a history of mental illness and illicit substance misuse. Glen was engaging with mental health

[34] SCAS has informed the Review that they do not hold this type of information in any other system other than the clinical record for the incident. They do not flag this type of information unless it is part of a patient management plan, which is part of a multi-agency plan.

[35] 'Was in drink' is a reference to a person being under the influence of alcohol

services at the time of the incident but had disengaged from substance misuse treatment.

2.12.3 The Local Learning Review also details the events leading up to the tragic event. In March 2019 Police attended Glen's address following reports from neighbours that he was smashing up his property. Due to Glen's presentation he was taken to MKUHFT. There was no street triage team available to support Police at that time. On admission to A and E Glen was deemed not fit for assessment and it was agreed he would be seen by the mental health liaison team at a more suitable time. He tested positive for multiple illicit substances. At this point there was some confusion about when Glen was referred for assessment and as a result Glen was discharged the next day before an assessment could be carried out.

2.12.4 From hospital Glen was taken to custody due to unmanageable behaviour. The Mental Health Liaison Team advised the Police to use section 136 Mental Health Act if his behaviour continued to cause concern.[36] Later that morning Glen was taken to a health-based place of safety by the Police however apparently no warning was given to the practitioners on duty that this was happening. The on-call psychiatrist was contacted and advised that another person on the list would be better placed to attend. The approved mental health professional (AMHP) went on to arrange a full Mental Health Act Assessment. Following this assessment, it was determined Glen was not suitable for detention under the Mental Health Act 1983.[37] Glen was therefore discharged back to custody where he continued to display concerning behaviour.

2.12.5 On Sunday xx March 2019 a decision was made that Glen was fit to be detained. Glen consulted with a solicitor and an appropriate adult (his mother), and he was given medication. An interview, however, did not proceed due to a deterioration in Glen's

[36] Section 136 of the Mental Health Act 1983 gives the police the power to remove a person from a public place, when they appear to be suffering from a mental disorder, to a place of safety. The person will be deemed by the police to be in immediate need of care and control as their behaviour is of concern. It is important to point out that a person is not under arrest when the decision is made to remove the person to a place of safety. The police power is to facilitate assessment of their health and wellbeing as well as the safety of other people around them.

[37] The Mental Health Act cannot be used to detain someone who doesn't meet the criteria. Under the Mental Health Act 2001, a person maybe involuntarily admitted and detained in an approved psychiatric centre if the person is suffering from a mental disorder. The person may not be admitted because they are suffering from a personality disorder, are socially deviant or addicted to drugs or intoxicants.

behaviour, which was noted by his solicitor Linda. A decision was taken to release Glen under investigation, whereupon he left custody at 12.19pm and he and his mother were taken to his parents' address by Police Officers. Approximately 27 minutes later a 999 call was made from the address following the serious attack.

3. Analysis

3.1 Analysis

3.1.1 Overall, witnesses to the Review say that Glen was civil with his parents Henry and Heidi. He admired Henry and talked very proudly of him and how he had fought in the Korean War and had sustained a brain injury. That said, there is also information presented that Glen was chastised by Henry and Heidi and denied his possessions as a child and young person. In later life it appears that Glen replicated some of these behaviours in his relationship with his former intimate partner and her son. The DHR Reviewers considered whether this was a consequence of adverse childhood experiences (ACE) but noted the paucity of the evidence to support this contention.

3.1.2 Glen felt that he had been treated differently to his sister Kim. Kim achieved well academically, had a successful professional career, her own home and a stable relationship with her partner Igor. Glen felt that he was the opposite and felt inferior or 'smaller' in many ways. As highlighted earlier, at the age of 18 Glen had cosmetic surgery to change his facial appearance.

3.1.3 Police Officers coming into contact with Glen in 2016 and 2019 recognised that he was experiencing mental health problems. Even after being arrested for substantive offences, they sought to prioritise suitable care and assessment to meet his needs.

3.1.4 The evidence provided by Compass indicates that Glen did not engage with services. Heidi contacted Compass inJune 2016 stating that she was worried about him. Further, Compass agreed to visit Glen at the Campbell Centre the following day. This meeting did take place and resulted in Compass reviewing their arrangements for lone staff visits to patients within secure units following an adverse incident. A number of attempts made to contact Glen by telephone are noted whilst he was an in-patient at the Campbell Centre. For example, the Compass team made three unsuccessful attempts to try and engage directly with Glen betweenJuly and September 2016. These calls were complemented by three additional calls to the Campbell Centre between July and August 2016. There was also a failed telephone call to Glen at the end of 30 September 2016 after his release as an in-patient from the Campbell Centre. There is clear evidence that Glen was not accessing the specialist services provided by

Compass. A more determined effort could have been made by Drug and Alcohol professionals at Compass to meet with him and positively encourage and influence his motivation for active participation in their programme whilst Glen was an inpatient.

3.1.5 Compass was liaising with mental health services to try to support Glen and participated in professionals' meetings and a discharge planning meeting in August 2016. Compass assert that they were able to offer support to Glen's mother Heidi when she called as she was concerned about her son. The nature of the support provided to Heidi is not wholly apparent, particularly whether this involved referral to an organisation equipped to deal with supporting older people as carers.

3.1.6 In terms of interactions with the Police, Glen had hitherto no previous convictions for violence. However, prior to his arrest in March 2019 Glen had been arrested and prosecuted on two previous occasions, namely in 2000 for an alleged assault with a wooden bat outside a pub, which resulted in an unsuccessful prosecution. In 2006 Glen was then arrested and convicted of Harassment against a neighbour and her family.

3.1.7 Glen has displayed physical and verbal violence to others as well as violence towards his own property. Glen kicked out and assaulted a Police Officer in an ambulance escorting him to hospital resulting in his arrest in March 2019. Glen was handcuffed and resisted being detained by Police Officers. The following morning he also 'moved away' from the escorting officer whilst having a cigarette outside a hospital building where he was awaiting an assessment after his detention under section 136 MHA. In effect, this may have been an attempt to run off and escape the Police.

3.1.8 Glen was also verbally abusive and insulting to Police Officers, nursing, security staff and one of his neighbours. On the whole these actions were directed towards professionals who were trying to treat, assess or restrain Glen, and whilst he was apparently experiencing mental health crisis. These, sometimes unpredictable outbursts, led to Glen being restrained invariably by Police Officers in handcuffs and leg restraints, sometimes for prolonged periods of times. For example, after he was detained by TVP officers and taken to hospital on two dates in March 2019. The Use of Force Records[38] for this period show that leg restraints were removed by officers

[38] NPCC, Home Office releases first national Police Use of Force statistics for England and Wales https://news.npcc.police.uk/releases/home-office-releases-first-national-police-use-of-force-statistics-for-england-and-wales

covering 18:28 - 22:06 hours bed watch (sic in March 2019), and that handcuffs were moved to front stack for comfort.[39] In addition, the handcuffs were removed by the night shift officers and there appears to be no record of them being re-applied until the incident when Glen attempts to make off whilst having a cigarette the following morning, he is detained, taken to the ground and a struggle ensued. This may have indicated that Glen was a potential risk, especially to those who were immediately caring for him. Indeed, a Police Custody Officer comments in his statement later that he considered that being in the custody environment may have contributed to Glen's behaviour (see paragraph 2.5.22). Consideration should be given to the impact of the lengthy restraint of detainees in a hospital setting whilst they are awaiting assessment. It is noteworthy that it was a Police decision that Glen should be removed from the Campbell Centre and assessed at the Police Station instead.

3.1.9 The Mental Health Act 1983 (Places of Safety) Regulations 2017[40] states that an adult may only be removed to, kept at, or taken to, a place of safety that is a police station (to which section 136A of the Act applies) where the behaviour of the adult poses an imminent risk of serious injury or death to that person, or to another and because of that risk, no place of safety other than a police station in the relevant police area can reasonably be expected to detain the adult. This Act also stipulates that where the decision-maker is not an officer of the rank of inspector or above, an officer of that rank or above authorises the adult to be removed to a police station, be kept at, or be taken there as a place of safety. There is no evidence that a Police Inspector authorised this to take place.

3.1.10 In addition, before determining the circumstances a police decision-maker must, if it is reasonably practicable to do so, consult: a registered medical practitioner, a registered nurse, an approved mental health professional or a person of a description specified in regulation 8(1). Suffice to say, hospital settings are the most appropriate place of safety for people experiencing a mental health crisis.

---

[39] Home Office, Police use force statistics, England and Wales, April 2018 to March 2019 accessed via https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/853204/police-use-of-force-apr2018-mar2019-hosb3319.pdf

[40] Mental Health Act 1983 (Places of Safety) Regulations 2017

3.1.11 The Panel questioned why the Police chose to take Glen back to the Police Station for assessment whilst he was awaiting MHAA at the MKUHFT. The DHR Reviewers queried why there was a preference for a Section 136 assessment to be undertaken at the Police Station. It is noteworthy that Glen was then taken to the Campbell Centre the same day for a MHAA, which could have been undertaken earlier.

3.1.12 Once assessed at the Campbell Centre on Saturday in March 2019, it is surprising that Glen was returned to police custody without any accompanying paperwork detailing the assessment, which would have been of vital importance to the Sergeant and the HCP working in the custody suite.[41] The Custody Sergeant and Glen's solicitor Linda remained concerned resulting in a request for a reassessment by the visiting mental health team who were at the police station seeing another detainee. The evidence before the Panel confirms that this request was declined due to Glen's drug presentation.

3.1.13 The Custody Officer and those contributing to the decision-making to release Glen did not report a specific risk to Glen's family. The Custody Officer did note a pre-release risk 'Level 2 (Raised)' and identified a small number of control measures to mitigate that raised level as identified in paragraph 2.5.21.[42] However, the information from which the assessment is based appears not to consider the TVP Command & Control log entry - just under three years earlier, from early June 2016 when Glen had discharged himself from hospital and was behaving in an erratic and paranoid way outside the hospital. The log contains an entry that Heidi reported that she and her husband, Henry, were unable to take Glen home and care for him as they were elderly. The documented pre-release risk assessment indicates that the Custody Officer wasn't sighted on the fuller information picture relating to Glen and his parent's ability to safely care for him. That said, this additional information would not have prevented Glen's release from custody but may have prompted questions about whether releasing him into the care of his mother was appropriate or not, and in turn informed the partnership's collective 'jigsaw picture' of risk to more effectively manage the threat, risk and harm.

[41] The Custody Sergeant is a rotational role and who manages the custody suite, including the care and welfare of detained persons and takes the decision to authorise or refuse the detention of any person presented before them. Ensures that while detainees are at the custody suite, police offices and police staff adhere to the Police and Criminal Evidence (PACE) Act 1984 Codes of Practice regarding the rights and treatment of persons arrested. For more information see https://profdev.college.police.uk/professional-profile/custody-sergeant/

[42] There are 4 levels of risk with 4 being the highest. See footnote 28

That notwithstanding, at that moment in time the viable options open to the Custody Officer following his decision that the threshold test for charging was not met, were restricted.

3.1.14 Following his release from Police detention, Glen was transported in the caged section of the Police van whilst his mother was seated elsewhere with an escorting Police Officer. The Police Misconduct Investigation Report (page 15 paragraph 9.4.4f) states *'…it appears that the decision to transport [Glen] in a Police van following his release was taken purely out of safety concerns, and due to the fact that he had carried out a dirty protest when in his cell and officers concluded that the van was the appropriate means of transport…this is a perfectly normal method of transporting individuals and does not necessarily represent any risk to persons being transported in this way'*. The Panel addressed their mind to whether this approach would have been different had Glen been offered a further opportunity to wash and shower prior to his release. It appears that the Police Officers transporting Glen, had decided that Glen would be placed in the cage essentially for safety reasons.

3.1.15 Comments made by Glen to the Police and others after his attack on his parents suggest that Glen intended to kill himself and that he wanted to protect his parents from that by killing them. It is known that suicide ideation, which then manifests itself in homicide–suicide, is a high-risk factor in domestic abuse.[43] The DHR Reviewers, however, noted that in the EIPT meetings and during the MHAA on a date in late March 2019 it is recorded that Glen 'denied ideas of self-harm, suicide or having delusional beliefs...' There was no indication from Glen's contact with Police prior to this incident that he had any determined intentions of committing suicide or self-harm, although the matter of suicide was indicated in some of his contacts with mental health professionals. The only recorded attempt at self-harm appears to have taken place when Glen grabbed and swallowed an unknown number of pills at his home earlier in March 2019 when Police were dealing with him.

3.1.16 The health evidence presented to the Panel indicates that Glen was experiencing a mental health crisis. He was seen by the Mental Health Assessment Team at the Campbell Centre and demonstrated bizarre and uncharacteristic behaviour in the presence of A and E hospital staff, Heidi, the Police, his legal representative and

[43] DASH risk assessment. SafeLives 2015

the SCAS. The SCAS noted in later March 2019 that Glen was known for having mental health problems. The crew recorded 'Past Medical History as mental health and specifically Psychosis'. Health professionals needed to consider whether this current episode experienced by Glen resembled that of 2016. Whilst it is accepted by the Level III NHSE Reviewer that Glen 'was seen at the Campbell Centre by an experienced team who completed a Mental Health Assessment; symptoms of psychosis were not present when the team saw him, although it does appear that they were present before and afterwards. Although it will be difficult for non-experts to understand, it does not appear to our team that the assessment was therefore flawed', a trawl of available information for the purposes of the Mental Health Assessment was not undertaken for Glen. As a result, Glen was not detained under Mental Health Act and was released into the care of Heidi by the Police.

3.1.17 The learning for TVP has included recognising that a Police Officer's documentation of events at the hospital is an area for improvement as the information was communicated to/briefed to Police Officers at handover time by 'word of mouth', with some Police Officers also recording information in their personal issue official notebooks. However, the likely consequence of this is that this practice most likely led to a dilution and loss of information between them and also from officers to healthcare professionals.

3.1.18 Glen's disruptive, threatening, violent and racially abusive behaviour was not notified to the clinical team therefore potentially affecting their medical assessment of him. Furthermore, this meant that the threat and risk Glen posed to healthcare staff, other patients and Police Officers had not been as effectively assessed as it could have been, given the absence of all of the information between the "bed watches".[44] Had Glen been arrested and detained at a TVP Police Station and then been transferred to a medical establishment whilst still in Police detention, the escorting officers would have been required to complete a custody form PAC41G, which documents the care, treatment and all occurrences affecting the detained person, whilst the detainee is in the care of officers outside the detention facility and the control of the custody officer.[45]

[44] A person who has been detained in hospital and is under guard by Police
[45] Section 39 PACE Act 1984 governs this particular area.

3.1.19 Section 39 Police and Criminal Evidence Act (PACE) 1984 states:

39 Responsibilities in relation to persons detained.

(1) Subject to subsections (2) and (4) below, it shall be the duty of the custody officer at a police station to ensure—

(a) that all persons in police detention at that station are treated in accordance with this Act and any code of practice issued under it and relating to the treatment of persons in police detention; and

(b) that all matters relating to such persons which are required by this Act or by such codes of practice to be recorded are recorded in the custody records relating to such persons.

(2) If the custody officer, in accordance with any code of practice issued under this Act, transfers or permits the transfer of a person in police detention—

(a) to the custody of another police officer at the police station where the person is in police detention, for the purpose of an interview that is part of the investigation of an offence for which the person is in police detention or otherwise in connection with the investigation of such an offence; or

(b) to the custody of an officer who has charge of that person outside the police station,

the custody officer shall cease in relation to that person to be subject to the duty imposed on him by subsection (1)(a) above; and it shall be the duty of the officer to whom the transfer is made to ensure that he is treated in accordance with the provisions of this Act and of any such codes of practice as are mentioned in subsection (1) above.

3.1.20 The Panel recommends that TVP generate a policy and relevant accompanying corporate/force level documentation to enable Police Officers to accurately document every interaction and incident involving arrestees who have been taken direct to hospital or other medical facility. This document can usefully be deployed by Police Officers who are taking over a "bed watch". It can also inform healthcare professionals and the Custody Officer about incidents to inform their clinical assessments and decision-making, and in the case of the Police to check compliance with PACE Act 1984 and the accompanying Codes of Practice.[46] In addition, such a document, would enhance the effectiveness and the quality of information exchange and inform the risk assessment, risk identification and risk management for the benefit of Police Officers,

[46] Ibid

health professionals, the patient subject to the risk assessment, other patients and visitors.

3.1.21 The evidence presented to the Panel suggests that support strategies had not been devised for Heidi who stepped in and out of the role of carer for Glen. As a carer Heidi regularly looked after her son and provided financial support whilst living in her own home. Heidi contacted her GP when Glen had disappeared. She also informed the Police that Henry and herself were elderly and could not look after Glen in 2016 (this was noted on a Police Command and Control Log as per paragraph 3.1.10). More recently Heidi shared concerns about taking Glen home from the Police Station on the day of the incident but this is at odds with the Police account. The Custody Sergeant has stated in the Police Misconduct Report that no issues were raised with him regarding alternative options for Glen's release from custody (para 9.4.1). The Police Officers and Glen's solicitor noted his bizarre behaviour in the custody suite yet this did not trigger referral to a support organisation for older people acting as carers. Heidi was advised by the Custody Sergeant to call them should Glen's 'behaviour not improve where officers could attend and consider 136' but this begs the question what Heidi would have been able to do in light of the difficulties that the Police had had in restraining Glen following his challenging behaviour.

3.1.22 The DHR Reviewers noted the Police Misconduct Report at paragraph 9.4.4f indicates 'it appears that the decision to transport Mr … in a police van, following his release, was taken purely out of safety concerns and due to the fact that he had carried out a dirty protest when in his cell and officers concluded that the van was the most appropriate means of transport. No concerns as to this were raised at the time by Mrs … nor by Mr .... The officers described him as being chatty and cordial throughout the journey. This is a perfectly normal method of transporting individuals and does not necessarily represent any risk to persons being transported in this way'. This account is as indicated above at variance with Heidi's recollection regarding her concerns at the time. The Police safety concerns prevented Glen from being taken home by Heidi's neighbour who was waiting at the Police Station to take them home. Heidi's neighbour, Mick, has indicated that he sat outside the Police Station and expected to drive Heidi home yet she travelled unexpectedly in the Police vehicle with Glen at the insistence of the Police.

3.1.23 The Police information before the Panel is that they were not aware of any previous incidents of physical violence, abuse or coercive control, between Glen and his parents. Linda, Glen's solicitor has confirmed that there were few options available to the Police.

3.1.24 Heidi received limited support from her GP regarding the management of her son. There is little evidence to indicate that steps were taken to address the impact of Glen's behaviour on both Henry and Heidi, particularly in light of disclosures (detailed in the chronology by Heidi to her GP) that she was finding it difficult to cope with Glen and his mental health. CNWL indicate, however, that discussions relating to Glen's care took place twice in August 2016 whilst Glen was in the Campbell Centre. A carer's session was offered to Heidi and Henry but it is unclear if this was taken up. There is no evidence that this offer of support was re-iterated or otherwise followed up. Indeed there is no evidence that Henry and Heidi were recognised as carers and furthermore there is no evidence that a carer's assessment was undertaken.

3.1.25 On the date of the tragic event Heidi did not want to take her son home as she could see he was not himself and unwell. She knew this as a mother, a carer and a medical nursing professional of 40 years' experience. The actions of Police Officers and health professionals appeared not to take account of the impact of Glen being released to the care of his elderly mother. Of note is the fact that Glen's legal representative, Linda, who was present at the Police Station was unable to engage with him to provide legal advice and take instructions thereafter. Heidi was seen by the Police to chastise Glen for swearing prior to being transported to A and E in March 2019. Police Officers who observed Glen interact with his mother reported that she appeared to have a calming effect and that he was apologetic and respectful of his mother and hugged her when Heidi attended Police Custody in the capacity of appropriate adult. That said, Kim stated that in her experience hugging was not something that was usually done in the family.

3.1.26 Glen's legal representative was present when the Custody Sergeant had invited members of the Campbell Centre Mental Health Team, who were in the custody suite dealing with another detainee, to reassess Glen. This request was declined and as a result the Police, in their view, had no option but to release Glen as there were no

grounds for his continuing detention. Whilst Glen was asked if he wanted to return to the Campbell Centre voluntarily, or go home, he stated that he wanted to go home. He should therefore have been returned to his own home address and not that of his parents.

3.1.27 There is no record to suggest that the Custody Sergeant or Officer in the Case (OIC) explored further with Heidi, possible alternative arrangements such as other family members, health, social care and voluntary groups who could support them over the weekend (and beyond) with Glen on his release. They were given a leaflet containing the details of support organisations at the time of Glen's release from custody.

3.1.28 In terms of "seeing beyond" the professional and legal requirements to improve Glen and his family's predicament, such a discussion may have prompted different arrangements on Glen's release and may have reduced Heidi, Henry and Glen's vulnerability. This discussion may have been more likely if the Custody Officer was aware of the offer of help from Glen's brother-in-law Igor and sister Kim who live in Bedfordshire.

3.1.29 Had any risk or threat of harm been disclosed to the Police then this should have been identified as a domestic incident and a TVP 'DOM5' risk assessment completed. A number of high-risk factors usually associated with abusive relationships were present in this case including Mental Health, possession of potential weapons, Drugs (illicit and prescribed), Alcohol, Financial problems, Complex Needs and Community Isolation. Equally the social isolation is applicable to Henry and Heidi. Better understanding of individual and structural barriers to seeking support, as well as exercising professional curiosity would enable identifying older people's and carer support needs. This is relevant whether the carers are officially recognised or paid in the role or not. However, there was no record of knowledge of family related/intra-familial violence in Glen's case and so it is unclear if this would have or could have prompted a different response in supporting Glen upon his release from Police detention.

3.1.30 Heidi recalls being dropped at her home address with Glen and left to walk back to her home. There was no clear attempt made to ensure that Heidi was alright and

able to manage Glen. These issues are particularly pertinent with older people who are undertaking some form of carer role with adult children. Research has identified that carers face their own mental ill-health as a direct consequence of their caring role and experience higher rates of mental ill-health than the general population. The burden of carers[47] is a complex process and is related to gender, age, health status, ethnic and cultural affiliation, lack of social support and coping style. In addition to the stressors of the disorder itself, carers appear to suffer from at least moderate levels of psychological symptomatology. The behavioural problems associated with mental disorders further increase the stress levels of carers.[48]

3.1.31 A Police Adult Protection Report is the means by which other agencies may be informed via the MASH of additional services and support that an adult at risk might need. The Adult Protection Report, however, would be made in respect of Glen and not of his parents in this case, unless the reporting professional had recognised that Glen's elderly parents may have been experiencing difficulties coping with him. Difficulties had been mentioned previously by Heidi and professionals could, therefore, have made a referral and informed Heidi and Henry that a referral was being made outlining the reasons if required. In addition, this could have been the subject of consideration and decision-making by the MASH. Heidi may have benefited from direct contact from agencies to assess her needs and requirements to look after Glen.

3.1.32 The Police have a common law duty of care to any detainee and a duty to release them into a safe environment. The College of Policing's Authorised Professional Practice states that beyond the expiry of the provisions of the PACE Act:[49]

> *"a person may also be kept for a minimal and limited period to allow for the transfer of care to other appropriate care services, e.g. transfer into social services or local hospital care facilities…."*

[47] NHSE defines a carer as 'A carer is anybody who looks after a family member, partner or friend who needs help because of their illness, frailty or disability. All the care they give is unpaid

[48] BJMP 2010;3(3):a327 Psychological Distress in Carers of People with Mental Disorders Aadil Jan Shah, Ovais Wadoo and Javed Latoo

[49] APP: Detention in Custody: Risk Assessment. College of Policing 2019

However, in this case it is difficult to conceive what suitable provision might have been identified as immediately available for Glen and his needs after he declined to voluntarily attend the Campbell Centre post release.

3.1.33 Glen and Heidi were supplied with a leaflet providing details of such organisations and advised that they might want to contact Glen's GP the next day for support. Heidi was also told to call the Police if Glen's behaviour deteriorated. One wonders what the Police would have been able to effectively do - aside from further detaining Glen for offences or a section 136 Mental Health Act Assessment, as they would have been back in the same impasse as they had most recently found themselves in. That said, the Custody Officer followed the Police guidance. No guidance could be found to suggest what alternative arrangements could be made if no suitable accommodation or support was immediately available to a detained person on release. It is not uncommon for detained persons to be released from custody with no fixed abode.

3.1.34 Glen's MHAA prior to the trigger incident concluded that he did not require statutory detention care in hospital. But Police found Glen was unfit for interview and the Police decision makers further assessed that the only applicable option, given all the circumstances, was to release Glen under investigation. Following a risk assessment, the Police identified that there were no indicators of serious risk presented by Glen. The Police pre-release risk assessment identified that there was a Level 2 (of 4 levels, whereby 4 is the highest level of risk) meaning a 'Raised Risk'.

3.1.35 It is surprising that other referrals for support had not been made to the MK Adult Social Care from Police and healthcare about Henry and Heidi. Despite their advancing years they were remotely caring for Glen, which evidence suggests was taking its toll on them. Heidi's neighbour Mandy, for example, had seen Heidi at the bottom of her garden crying on several occasions. We are also aware of Heidi's request for assistance in 2016 when she informed the Police that Henry and herself were elderly and could not look after Glen. In addition, the role of frontline professionals such as the Community Occupational Therapy Team are vital in the prevention and early intervention of family related abuse and other forms of abuse provided they are trained to identify the signs and 'red flags' of abuse and to exercise 'professional curiosity'. As previously

highlighted CNWL indicate, however, that a carer's session was previously offered to Heidi and Henry but there is no evidence that this was followed up.

3.1.36 The effective working practices identified from the Local Learning Review includes the Approved Mental Health Professionals (AMPH) (who work for the local authority), on duty at the place of safety who arranged for a MHAA, and the AMHP who emailed the Early Intervention in Psychosis Team to advise that Glen needed to be followed up by his Care Coordinator rather than leaving him to make contact.

3.1.37 A number of key areas for learning have been identified by the Local Learning Review including:

a. CNWL review their crisis pathway as part of a wider transformation, which should provide more capacity to support Thames Valley Police when they are responding to incidents where mental health is a concern.

b. Processes to be reviewed to ensure that all practitioners ascertain whether a patient in A and E and referred to MHHLT are known to Adult Mental Health Services.

c. Identifying some communication difficulty between the Mental Health Liaison Team, A and E and the person who made the referral for a mental health assessment, therefore it would be beneficial in clarifying the referral process between A and E and the Mental Health Hospital Liaison Team to ensure that patients requiring a mental health assessment are seen promptly

d. Multi-agency training would benefit the system in working together, understanding roles and responsibilities and legal literacy with thresholds and boundaries. This needs to take place regularly to take account of change in personnel within all agencies.

e. The need to ensure that the AMHP provides some written information to the Police when a person is discharged from section 136 Mental Health Act. A letter of no detention should be produced and given to the Police.

f. An assessment that over the course of the weekend there was a breakdown within the multi-agency partnership, leading to conflict between the Police, the AMHP Service and CNWL.

   There was a lack of knowledge around escalation policies within CNWL and Milton Keynes City Council. It appears that CNWL and the AMHP Service did not understand the Police requests for assistance. The Police are not experts in accessing specialist mental health services whilst the mental health services are well-placed to advise and support. On-call information needs to be circulated to all who need to know.

g. CNWL has already started to review forensic pathways as there appears to have been a gap in commissioning. There is now access to the London Offender Care Services where there is access to psychiatry. Work to review the forensic pathway continues. Once arrangements have been agreed the pathway needs to be communicated to all agencies and will be included in any awareness training. CNWL should keep MK Together Safeguarding Partnership regularly updated regarding progress in this area.

3.1.38 CNWL Mental Health Trust, Milton Keynes (MK) City Council and Thames Valley Police (TVP) Senior Management have already agreed a process to improve communication when handing over responsibility between the section 136 MHA assessing team and TVP including a summary of reasons why someone has not been further detained under the Mental Health Act. This information will be provided in writing by the assessing AMHP to the TVP custody staff.

3.1.39 CNWL has undertaken the following action:

- Section 136 Mental Health Act Standard Operational Policy has been reviewed and circulated to all staff

- Contact details of 'out of hours' agencies' senior staff have been updated in the senior managers on call pack
- Multi-agency meeting with MK City Council, CNWL and Police called to review case and ensure cross agency learning took place in April 2019, which identified a number of areas for improvement as stipulated in paragraph 3.3.2 as well as items of good practice.

3.1.40 The Police have already identified key learning in relation to their process. TVP's Form PAC 41G is a Detention Log for detainees requiring hospital treatment. This form, as well as providing details of the discharging Custody Officer and the reasons for requiring treatment etc gives space for a running or contemporaneous log to record any action or occurrence involving the detainee. The guidance on the form requires that the form should stay with the detainee until they are returned to custody or released and that any medical advice or instructions should be detailed on the form.

3.1.41 Had there been a Liaison and Diversion[50] professional working in Milton Keynes Police Custody that weekend, this may have improved communication and provided a more coordinated level of service and more effective sharing of information between professionals. That said, it is unlikely it would have impacted on the outcome of any MHAA.

3.1.42 The Police information confirmed that the threshold test for charging Glen at the Police Station was not met for the charges of Assault on an Emergency Worker (a Police Officer) and for the racially and religiously aggravated Public Order offences. A charge *was* authorised by the Crown Prosecution Service (CPS) the following day for the same offences following the then two charges of attempted murder. The Custody Sergeant, in Glen's case, did not seek an emergency charging decision from the PACE Inspector as the authorised period of detention (24 hours) was nearing its conclusion, nor did he seek CPS authorisation for charge due to the time involved. It is noteworthy that the CPS advised charges on the same evidence the following day for the Assault on an Emergency Worker and the Public Order Act Offences. This prompts the question

[50] NHS, Laison and Diversion, Frequently Asked Questions accessed via https://www.england.nhs.uk/commissioning/health-just/liaison-and-diversion/ld-faqs/

as to why Glen was not charged using the Threshold Test on the evidence and remanded overnight in custody to appear at court.[51]

3.1.43 An audit of the 999 call was undertaken by SCAS, which identified some areas for improvement for the operator. To enable a call to be safe the call taker must achieve a minimum score of 86% and on this occasion the call handler achieved an assessed score of 65% falling below the minimum standard. The regular audit of call handlers' performance, effectiveness, efficiency and support for its call handlers is an area for development by SCAS.

3.1.44 The perpetrator's propensity to physical violence, violent and threatening words and behaviour, jealousy and abusive conduct including the use of control has been seen in different settings involving his family members, a neighbour and intimate partner and her son. Allied to these aspects of DA perpetration, there were also signs and indicators of economic abuse, which was also an aspect of Glen's controlling behaviour. For example, Glen was provided assistance from his parents to help pay for his mortgage, and sought their assistance to pay off his debts with different companies chasing him for debt repayment (Kim's statement, page 184), whilst he is thought to have spent a significant amount of money on buying illicit drugs and alcohol. There were further signs of economic abuse during his intimate partner relationship with Diana (paragraph 2.4.23) regarding the separate fridge for his food (paragraph 2.4.23) and another fridge for Diana and her son, and whilst also preventing Diana turning up the thermostat in winter. `

3.1.45 It is of note that the 5 major events depicted in paragraph 2.4.19 in which it is believed by family, friends, and Glen's former partner contributed to the decline in his mental health and his consumption of illicit drugs and alcohol – all have a notable financial management element to them, leading to a decline in his economic position. These major events may have influenced and shaped his relationship with money.

[51] The Code for Crown Prosecutors, 26 October 2018 accessed via https://www.cps.gov.uk/publication/code-crown-prosecutors

3.2 What might have helped?

Police

3.2.1 The Panel noted the TVP's view that there were no circumstances, specific to the time or location of these incidents, which have been identified as relevant or thought to have impacted on Police decisions. However, the pressures experienced individually and organisationally from the demand caused by mental health commitments are very apparent to/for the Police.

3.2.2 This Review highlights the paucity of provision for individuals suffering mental health crises who come into contact with the Police, in particular outside usual office hours and notably at weekends. This is not unusual in UK policing. Examples in this case include:

- the requirement for the Police to respond to five incidents in eight days in June 2016 in relation to Glen's mental health;
- Police cars being used to transport Glen as a patient when ambulances have been unavailable or significantly delayed;
- Glen waiting for a mental health assessment on a hospital ward needing restraint and being abusive to staff over a prolonged period of time, then a further three hours in a section 136 suite; and
- Glen being transported and held in a Police van for several hours whilst a place of safety could be found.

3.2.3 Similar circumstances are reported as regularly occurring scenarios across the country in the Her Majesty's Inspectorate of Constabulary, Fire and Rescue Services inspection in 2018 exploring Police and mental health entitled "Picking up the Pieces".[52] This report states:

"…too many aspects of the broader mental health system are broken; the police are left to pick up the pieces. The fact that almost every police force now has its own mental

[52] HMICFRS, Policing and mental health: Picking up the pieces, (November 2018) accessed via https://www.justiceinspectorates.gov.uk/hmicfrs/publications/policing-and-mental-health-picking-up-the-pieces/

health triage team indicates that there isn't nearly enough emphasis on early intervention and primary care to prevent the need for a crisis response.

This is letting down people with mental health problems, as well as placing an intolerable burden on police officers and staff."

The DHR Reviewers would assert that this is placing an intolerable burden on those individuals in paid and unpaid / recognised and un-recognised carer roles too.

3.2.4 The introduction of the Street Triage provision, supporting front line Police Officers during peak demand times helps to bridge a significant gap, examples of which are in this Review. However, this case has also seen examples where this provision has not always been available when needed, either because it is committed elsewhere or there is no resource on duty at the relevant time. This may highlight the requirement for resources and capability to meet this need.

3.2.5 The Police have acknowledged that there was no Liaison and Diversion (L&D) provision in Milton Keynes Custody over the critical weekend in March 2019. This begs the question as to whether this was due to the weekend and/or the lack of resources or the demand profile. The Panel noted the 2019 Service Improvement Review of TVP custody centres, which identified that the Milton Keynes area is under a different NHS Trust (that supply the provision) and that as a result L&D coverage was less consistent at Milton Keynes custody than elsewhere across the same force area, with most other areas offering seven days a week cover. Despite this, this Review maintains that it is unlikely a L&D provision would have impacted on the outcome of any MHAA in this case. L&D is a service introduced following the Bradley Report (2009)[53] where mental health professionals are present in Police custody with the objective of diverting detainees away from or supporting the most appropriate criminal justice outcomes for detainees with mental health and/or learning difficulties. L&D did, however, supply a report for court on the morning in March 2019 after Glen was charged, with a background to his mental health and a recommendation of what services he should receive if remanded in prison or released on bail. The presence of a L&D professional

[53] Lord Bradley's review of people with mental health problems or learning disabilities in the criminal justice system

would have been better placed than the HCP to understand, escalate or challenge the appropriateness of the decisions not to make subsequent MHAA of Glen on the two dates inMarch 2019. This Review has considered whether a flexing of the L&D services – with formalised agreement, across the Thames Valley area would enable better use of resources.

3.2.6 The Service Improvement Review of TVP custody centres in early 2019 noted this advantage: '*L&D resources are viewed as being better able to communicate detainees' needs to AMHPs than Custody Sergeants or Detention Officers. Custody staff felt L&D professionals are able to do so more concisely and utilised the appropriate terminology.*[54]

3.2.7 TVP has already undertaken a number of actions including:

a. *The Local Police Area Commander and Mental Health lead for TVP met with senior managers from Central and North West London NHS Trust and Milton Keynes City Council in the days following the incident. It was agreed that a safeguarding review would be beneficial to inform organisational learning.*

b. *It was identified following the incident that a number of Police managers were not aware of the Joint Working Protocol. Key personnel, including custody managers were notified about the protocol. (However, this Review has noted that the Joint Working Protocol is not easily visible on Police systems. The link on the Mental Health pages to the Knowzone was broken, and the version accessible in the Mental Health Operating Procedures is not the most up-to-date version).*

c. *Throughout Spring 2019 there was a programme of training for Custody Sergeants and Inspectors in relation to mental health processes in custody. However, this was not as a result of this case.*

d. *Since this DHR report has been submitted a new national partnership agreement was launched across police forces called 'Right Care, Right Person' which has been adopted by TVP. This is an agreement between police, health and other*

[54] Custody Service Improvement Review: March 2019. TVP

partners to ensure that 'individuals in mental health crisis are seen by the right professional'. The aim is to reduce the burden on policing mental health incidents, recognising too, that the police are not wholly equipped to deal with such incident. The NPCC & College of Policing have developed a national toolkit, which was released in July 2023.[55]

3.2.8 TVP records indicate that the Adult Protection Reports were not completed on two dates inJune 2016 in accordance with the 2017 Adult Risk Guidance. However, in June 2016 the MASH upon receipt of the Adult Protection Report, decided that a referral to mental health was not required because Glen was already known to the service. Had these reports been completed, an agency record of contact would have been created and enabled an easier search of incidents, information and 'intelligence' involving the same person. This would have enabled the linking of incidents occurring at different locations and the identification of any associated risks - such as the incident in early June 2016 creating a more informed picture. It is noted that the importance of this has been highlighted to Police Officers through training delivered since. It is recommended that training should be the subject of audit and review to ensure it is being consistently applied and how the learning is influencing a change to officers' behaviour and to front line service delivery.

3.2.9 The close proximity of events in March 2019 meant that the TVP Niche and Command and Control systems could have been immediately updated with a flag ('street index gazetteer') alerting call takers and attending Police Officers to potential risks presented by the occupier. However, this is dependent on the level of risk attributed and in this case the Police view was that a high level of risk was not identified. The capability of the timely addition of a street index gazetteer on the address of an individual presenting a risk is an area of consideration for TVP.

3.2.10 Had Police Officers allowed Glen to continue to take 'pills' and potentially overdose they would have been subject to severe criticism. However, the legal framework for restraint and/or detention can be ambiguous and this is evident in this

[55] NPCC, Media Centre Press Release, 26 July 2023 accessed via https://news.npcc.police.uk/releases/police-to-save-1-million-officer-hours-as-forces-adopt-new-model-to-ensure-specialist-care-for-health-incidents

case. The assigned Police Investigating Officer when Glen was in custody raises the question of whether the original detention was lawful, further illustrating the confusion in this area. The original Police Officers did not have the option of section 136 powers in a place of residence nor could they arrest for criminal damage as the damage caused was to Glen's own property. Restraint under the Mental Capacity Act 2005 was applicable here[56], given that there was evidence that Glen's judgement was impaired by drug use and an urgent medical assessment in A and E in relation to a possible overdose of prescription and non-prescription drugs was necessary. The Panel noted that the Police Officers' statements and updates to the Command-and-Control log do not detail the powers they were exercising to restrain Glen, which reinforces the ambiguity and/or lack of informed knowledge in this area. That said, in an operational context dealing with a spontaneous fast-moving event this is understandable.

3.2.11 Police Officers need to be satisfied that they have justification for restraining/detaining individuals who are experiencing a mental health crisis and make appropriate records justifying their decision making and their use of Common Law powers, section 3 Criminal Law Act 1967, Police and Criminal Evidence (PACE) Act 1984 and so forth regarding their use of force. The Mental Health Operational Guidance needs to acknowledge that not all circumstances are provided for by section 135 and section 136 Mental Health Act e.g. because they are in a dwelling and where there is not an immediate threat of harm. The guidance should reference the National Decision Model to assist Police Officers and managers in making difficult operational decisions and cross reference to the Mental Health Act and Mental Capacity Act, with examples of when powers are exercised.

3.2.12 The Police Officers, for example, did have alternative options, which were not considered. Depending on the circumstances these can include an arrest for Affray (section 3 Public Order Act 1986) or in Common Law, with Police Officers effecting an arrest for Breach of the Peace. That said, the Police Service's use of Breach of the Peace in the jurisdiction of England and Wales has been greatly discouraged over the years and there is much debate and case law[57] around the appropriateness of its use

[56] "Practical Application – The Mental Capacity Act 2005": College of Policing 2014 https://www.scie.org.uk/files/mca/directory/mca-college-of-policing-guidance-2.pdf?res=true

[57] Hicks and Others v The Commissioner of the Police of the Met [2012] EWHC 1947 (Admin) & (civil) Court of Appeal case [2014] EWCA Civ 3

in these circumstances[58]. There is also an acknowledgement that this is often the only option left available to Police Officers.[59] A core Policing responsibility in England and Wales is the Protection of Life, which is underpinned by Section 2 Human Rights Act 1998 i.e. The Right to Life and the Code of Ethics governing how Police Officers should perform their duties.[60]

3.2.13 To this end, TVP should provide clearer guidance in respect of available options to be considered, utilising the National Decision Model[61], in respect of responding to Mental Health for the benefit of its frontline staff, their managers and to control room supervisors. Indeed, because these are difficult areas of law, Operational Guidance should not shy away from addressing them. Police Officers should be provided with practical options to consider and a framework that supports them in making those difficult decisions. The current Mental Health Operational Guidance provides for cases where section 136 is applicable or where circumstances allow a section 135 application. It does not provide guidance where these are not appropriate or available and frontline emergency services often find themselves operating within the so-called 'grey areas'. Other sources of guidance that are referenced on the TVP's intranet, including the Mental Capacity Act Codes of Practice are long documents with many sections not directly applicable to the Police. In addition, there is some guidance on the TVP Intranet pages, "The Knowzone" on the Mental Capacity Act but these are not cross referenced in the Mental Health Guidance. As highlighted earlier in paragraph 3.2.7(d) this work will now be better supported with the new national partnership agreement 'Right Care, Right Person' adopted by TVP. [62]

3.2.14 Police Officers should understand the importance of the completion and the submission of the Mental Health Monitoring Forms which can also be used to influence improvements in service delivery and partnership working. The guidance needs to be

[58] https://mentalhealthcop.wordpress.com/2015/07/26/breach-of-the-peace/
[59] Briefing Document – Mental Health Act Amendments 2017: College of Policing 2017

[60] College of Policing, Code of Ethics, A Code of Practice for the Principles and Standards of Professional Behaviour for the Policing Profession of England and Wales, July 2014, accessed via https://www.college.police.uk/What-we-do/Ethics/Ethics-home/Documents/Code_of_Ethics.pdf

[61] Authorised Professional Practice: National Decision Model. College of Policing 2014
[62] NPCC, Media Centre Press Release, 26 July 2023 accessed via https://news.npcc.police.uk/releases/police-to-save-1-million-officer-hours-as-forces-adopt-new-model-to-ensure-specialist-care-for-health-incidents

updated to reflect improved ways of working and included in the Mental Health Operational Guidance.

3.2.15 When Police Officers and staff make risk assessments in respect of Mental Health, including when responding to calls for service and releasing detainees from custody, the risk to others i.e. family members and the wider community should also be considered and explored. If appropriate, details of other involved persons should be included in any Adult Protection referral made to partners.

MK GP Practice

3.2.16 The main learning for the GP Practice has been an understanding that patients with severe mental health issues are vulnerable individuals, particularly when there is poor engagement with services. This Review has highlighted that there is a need to ensure better follow up processes and awareness of the dynamics within the whole family. The GP's assessment of their patients with mental health problems does include a psycho-social element that reviews any areas in the patient's life that could cause worsening symptoms and these should be probed and followed up where necessary.

3.2.17 The GP Practice prior to this case had no procedure for DHR cases and had never been involved in one. This is in itself not unusual. They decided that any future DHR will be led by the practice Safeguarding Lead and the patient's usual GP, with support from their administrative team. The outcomes will then be discussed in the monthly Safeguarding team meetings and discussed with all practice clinicians.

3.2.18 The GP Practice acknowledged that there could have been more encouragement and follow up to try and encourage Glen to attend drug and alcohol counselling.

3.2.19 The GP Practice also recognised the need to ensure that all frontline clinical staff receive effective safeguarding training that includes domestic violence and abuse. This will be assessed at annual appraisals and review meetings. MK GP Practice staff will be expected to ensure that any suspicions of domestic abuse cases are brought forward for discussion at the monthly safeguarding review meetings. The MK GP Practice staff are also encouraged to place flags on the medical records of all patients with severe

mental health illnesses so that all medical staff are aware of their vulnerabilities and have the confidence to identify any signs of risky behaviours.

Compass

3.2.20 Compass learning highlights the safeguarding of staff members when lone working with mentally ill patients. Robust risk management systems are now in place, and staff are aware of lone working policies with mentally unwell patients. The need to record incidents and escalating concerns to other professionals and management teams is now clearly articulated. The DHR Reviewers also considered the need for proactive contact and engagement with service users where telephone contact cannot be made. It is the DHR Reviewer's view that Compass staff should have been more proactive in establishing contact. A number of attempts were made to contact Glen in 2016 between June and September which were unsuccessful. Compass staff did not appear to consider alternative approaches to contact Glen. Glen could, for example, have been seen in person on more than one occasion whilst he was detained in the Campbell Centre for three months.

3.2.21 Compass was attempting to address Glen's substance misuse. However, his lack of engagement meant that his issues were not addressed and in turn resulted in the absence of mental health care. The Panel noted that mental health services required Glen to address his substance misuse in the first instance before any follow up treatment creating what appeared to be an unbreakable cycle.

CNWL

3.2.22 CNWL has identified the issue of lack of follow up with vulnerable patients where staff are absent and/or have missed two appointments. That said, this identified issue did not directly impact the incident. The independent review commissioned by NHS England and NHS Improvement (Midlands and East region) to review the care provided by the Trust for Glen did not believe that the EIPT acted inappropriately. The NHSE Reviewer has identified twenty recommendations: seven for the Rapid Review, and also contains this DHR's recommendations. One additional recommendation from the Rapid Review relates to this DHR. The NHSE Review has identified the following areas of improvement and recommendations which the DHR Reviewers agree with:

i. CNWL are reviewing their crisis pathway as part of a wider transformation which should provide more capacity to support TVP when they are responding to incidents where mental health is a concern. The DHR Reviewers agreed with this assessment in light of the capacity concerns raised by TVP earlier in this Review Report;
ii. Processes need to be reviewed to ensure that all practitioners ascertain whether a patient in A and E and referred to Mental Health Hospital Liaison Team (MHHLT) is known to Adult Mental Health Services. The DHR Reviewers have identified the need for local arrangements for information sharing within statutory agencies and between the statutory agencies to avert silo working;
iii. There appears to have been some misunderstanding on behalf of A and E staff who assumed that a referral to the MHHLT had already been made prior to staff calling them on 'the date specified' in March 2019 at 8.45am. This was not the case and a referral had not been received by the MHHLT. There appears to be a need to ensure that all A and E staff are familiar with the referral process to MHHLT for a mental health assessment to ensure that patients requiring a mental health assessment are seen promptly. The DHR Reviewers concurred with assessment detailed in the NHSE Review;
iv. Multi-agency training would benefit the system in working together, understanding roles and responsibilities and legal literacy with thresholds and boundaries. This needs to take place regularly to take account of change in personnel within all agencies. The DHR Reviewers have concluded that a rolling training programme is essential to ensure that new staff are engaged as soon as practicable and updated with any recent changes in process and procedure;
v. There is a need to ensure that the AMHP provides written information to the Police when a person is discharged from section 136 Mental Health Act. A letter of no detention should be produced and given to the Police;
vi. Over the course of the weekend there was a breakdown within the multi-agency partnership, leading to conflict between the Police, the AMHP Service and CNWL.

There was a lack of knowledge around escalation policies within CNWL and Milton Keynes Council. It appears that CNWL and the AMHP Service failed to understand the Police requests for assistance. The Police are not experts in accessing specialist mental health services whilst the mental health services are well-placed to advise and

support. On-call information needs to be circulated to all who need to know. The DHR Reviewers are of the view that the on-call arrangements need to be consistent and suitably resourced to ensure that statutory partners have confidence in the delivery of this service at all times;

vii. CNWL has already started to review forensic pathways as there appears to have been a gap in commissioning. There is now access to the London Offender Care Services where there is access to psychiatry. Work to review the forensic pathway continues. Once arrangements have been agreed the pathway needs to be communicated to all agencies and will be included in any awareness training. MK Together Partnership needs to be periodically updated with development in this area.

MK Adult Social Care

3.2.23 MK Adult Social Care have highlighted the need for appropriate information sharing across different teams working with the same service-user or their immediate family. The need for individual workers to ensure they read entries on the Frameworki system that have been made by colleagues from other teams. Where a service-user dies, as tragically was the case here, all agencies working with that individual should be informed. The intention being to avoid making unnecessary contact with grieving family members. The team receiving the information relating to the death of a service-user will consult the case note records and will inform all Milton Keynes staff who are actively working with the individual.

3.2.24 However, that said, the need for sharing information across different teams providing services to the same service-user or family also has a direct impact on the approaches to health and social care 'surveillance' for prevention and early intervention and the whole family/think family approach to providing a more holistic service for the benefit of all.

3.2.25 The family were not known to services until March 2019 when a referral was made for Henry to Occupational Health. The Panel concluded that the lack of professional curiosity of the statutory agencies prevented a sustainable level of support being put into place for Heidi, Henry and Glen. It is acknowledged, however, that Glen's needs were intermittent and related to the exacerbations of his mental health.

SCAS

3.2.26 The SCAS learning has extended to the handling of the call following the tragic incident. The Call taker failed on the following areas:

a. **Skilled Questioning** - Ensures appropriate information is obtained to answer every question adequately. It was unclear at the beginning of the call whether the patient was breathing. More probing was required to determine this before moving the call on. It was 2 minutes and 42 seconds into the call before it was established that the patient was not breathing. When the caller advised that the patient was unconscious and bleeding on the floor, the ECT probed well to establish what had happened.

b. **Active Listening** - Listens carefully throughout the call and retains this information. When the caller went away from the phone, she could be heard telling someone in the background to call the Police. The ECT picked up on this and documented appropriately in ICAD. The ECT should have attempted to check out what had been heard, to ensure scene safety and to ascertain who else could have been on scene at the time of the call.

c. **Practices According to Designated Role Requirements** - Operates within the boundaries of their role. Has the ECT asked the appropriate pre-sieve questions as detailed in the EOC Nature of Call (NoC) flow chart and selected the correct NoC. NoC selected: C1 UNCONSCIOUS C1. It was uncertain whether this was the most appropriate NoC due to the ECT not establishing whether the patient was breathing at the beginning of the call, as per SOP 4-2. In addition, the ECT should have asked the pre-sieve question for unconscious patients. i.e. "Are they breathing noisily?" as per SOP 4-2.

d. **Delivers A Safe and Effective Outcome for the Patient** - Manages the clinical situation safely to reach a safe and appropriate outcome. Disposition - Emergency Ambulance Response for Potential Cardiac Arrest - DX010. Although this was an appropriate disposition there was a compromise to the

safety of the call due to the delay in the ECT establishing that the patient was not breathing.

e. **Manages all other inherent risks appropriately to reach a safe and appropriate outcome.** When it became clear that the patient had been attacked by his son, the ECT asked where the caller's son was. The caller advised that he had run off, however, it would have been best practice to ensure that the scene was safe for the crew to attend.

3.2.27 An ambulance was on scene within eight minutes. During the course of the investigation, it was also established that the ambulance crew who arrived on scene first were unaware of what they were going to other than an unresponsive male. Upon their arrival on scene the crew met Glen who had a small cut to his arm and who told them that there was no need for them to enter the property because his parents were fine. One of the crew members checked Glen whilst the other one entered the property and found Henry and Heidi. The crew requested urgent back up. This was clearly a dangerous scene for the ambulance crew to walk into without any prior knowledge of the situation. Whilst the situation was managed well by the crew, they were nevertheless exposed to potential risk.

3.2.28 The audit for the 'failed' call in March 2019 was fed back to the call taker for additional learning. In relation to the crew walking into a potentially volatile situation this was dealt with via the SCAS internal risk process. Due to the limited involvement SCAS had with Glen and his family, they assessed that they are not aware of any potential risks, which could have been missed.

3.2.29 The learning for SCAS has included ensuring that operational staff are updated about scene safety.

MKUHFT

3.2.30 Improvement in documentation of decision-making in patient recording systems is identified by MKUHFT as an area for improvement as are the documentation of risk assessments regarding clinical and non-clinical decisions in A and E, and access to mental health notes outside office hours.

The MK Community Safety Partnership

3.2.31 The Safer MK Strategy 2018-2021, in effect at the time of the homicide noted that Domestic Abuse levels remained relatively static in the area at over 4000 incidents per annum. However academic research continues to predict under-reporting. It was recognised as an area requiring development against a background of two ongoing Domestic Homicide Reviews and data from the Multi Agency Risk Assessment Conferences showing below average numbers of cases being heard and below expected LGBT representation.

3.2.32 A key priority in the strategy details the need to ensure effective partnership response to the tackling of domestic abuse including: service provision, working in partnership and tackling perpetrators. These are areas, which you expect to see in such a strategy and accords in part with the UK Government Violence Against Women and Girls Strategy 2021 – 2024 and its key priority areas.[63]

3.3 Identified good work

3.3.1 The Panel noted that the Mental Health Street Triage in mid-2016 facilitated a fast time street assessment for Glen providing him with the opportunity to calm down and receive advice regarding next steps for his mental health problems. However, resourcing issues for this service have been identified by TVP. It is noted that Glen was later admitted to hospital. There is nothing to suggest, however, that a hospital-based assessment at the time would have resulted in a different conclusion to that of the Street Triage professional.

3.3.2 On the specified date in March 2019 good engagement was exhibited by Police Officers to establish a proportionate response and support for Glen. Police Officers allowed Glen to return to his home and tried to safely locate the reported air weapons, even though they would have known that this would have then precluded them from using their section 136 MHA powers.

[63] Home Office, Tackling Violence Against Women and Girls Strategy (20 September 2021), accessed via https://www.gov.uk/government/publications/tackling-violence-against-women-and-girls-strategy

3.3.3 The Milton Keynes Domestic Abuse Prevention Strategy 2020 – 2025[64] was launched in the summer of 2020 and helpfully sets out the plan for the next five year recognising that domestic abuse continues to have a damaging and lasting impact on the lives of adults and children across Milton Keynes. The Domestic Abuse Needs Assessment 2018-20 estimated that approximately 12,000 adults in Milton Keynes will experience domestic abuse each year. However, despite the increase in information the number of people contacting Police and support services remains low. Sadly, domestic abuse continues to be a crime that people don't feel they can report. It is recognised that there will be individual[65] and structural barriers for this.

3.3.4 This Strategy has set out its Vision: "Milton Keynes is a place where domestic abuse is not tolerated and where everyone can expect healthy and fulfilling relationships."

It goes on to state how "local agencies are committed to the Health and Wellbeing Strategy to "stop all forms of abuse and exploitation, including domestic abuse" and Safer MK strategy to "Ensure effective partnership response to the tackling of Domestic Abuse."

3.3.5 The Strategy additionally sets out the aim making "sure that the right help and support is available so that fewer victims and their children reach crisis point, and the harm caused is reduced or avoided. If we are to realise this vision, domestic abuse must become everyone's business."[66] Prevention and early intervention is an essential priority in any strategy focused on preventing and tackling Domestic Abuse and wider Gender Based Violence genre as is having an active By-Stander Programme.

3.3.6 The Strategy recognises the need for clear and communicated pathways to services; the lack of availability of information in different forms or languages, training analysis and plan, workplace policies and champion schemes; gaps in engagement with under-represented groups (LGBTQ+, older and disabled people in particular); gaps

[64] Milton Keynes Domestic Abuse Prevention Strategy 2020 – 2025 accessed via Domestic Abuse Strategy 2020-25 (mktogether.co.uk)

[65] Ibid
[66] Ibid

in workplace guidance for managers/employers to identify victims' needs and support them; and Thames Valley BAME project findings for continued engagement.[67]

4. Conclusions and Recommendations

4.1. Conclusion

4.1.1 This Review has concluded that whilst there are areas of improvement for individual agencies and the collective partnership, Henry's homicide at the hands of Glen could not have been foreseen. This accords with the view of the NHSE Reviewer.

4.1.2 In this case it should be remembered that only one person, Glen, is responsible for taking Henry's life. However, in this Review it is the opinion of the Panel that better adherence to inter-agency procedures, protocols, information sharing and communication between agencies are key steps to prevent such a tragic homicide in future. It is also vital that a healthy culture of 'check and challenge' and 'professional curiosity' permeates the partnership, which is supported by the 'road testing' of multi-agency protocols and procedures outside recognised regular office hours including weekends. The Panel note however that the lack of adherence did not cause Henry's homicide.

4.1.3 In accordance with the DHR's Terms of Reference to amplify the victim's voice through family members and others; to hear and to listen to them, the Panel invited Henry's family members to meet with them in a virtual meeting (due to Covid-19 restrictions) and additionally to provide a complementary written submission.

4.1.4 Henry's daughter Kim and her husband Igor attended the virtual Panel Meeting in November 2020. Kim courageously provided the Panel with a thoughtful, insightful and powerful account of the dire impact on her and her family in the aftermath of the serious attack on her parents, her father's homicide, the ensuing Police investigative response, Glen's court appearances and conviction and the post-court period including Glen's detention at a secure hospital.

[67] Ibid

4.1.5. The Panel were struck by Kim's words, experiences and the short to medium term effects of her father's homicide and the actions and processes, which took place thereafter. Hearing the victims' family's voice firsthand sufficiently influenced the Panel. The family's account detailing the traumatic impact of Henry's homicide, the surrounding circumstances and their consequences resulted in the decision of the Panel to step outside the DHR's Terms of Reference to specifically draw attention to the impact on families - as in this case of fatal family related violence, exposure to the Police investigative response, the Criminal Justice System and its aftermath.

4.1.6 There is no doubt that this tragic crime has had a devastating impact on Heidi, Kim and Igor. Kim said "… All four members have suffered a life changing event and I have been left dealing with everything. … (sic my dad) is dead and (sic my mother) is alive, but suffering from the attack both physically, emotionally and mentally. She has lost both her husband and son". "…This whole event has caused her immeasurable distress and impacted on her blood pressure, sleep patterns, anxiety, with me being extremely concerned that she may suffer from a stroke or heart attack". "...The emotional and mental stress has been gigantic. My life has been turned upside down … I get tired very quickly and need to rest most days. My social life has been impacted, as I didn't want to see anyone or indeed have the space or time for the first three months after the attack….". "...Since the date in March, life has not been my own."

4.1.7 Kim and her family's experiences have shone a light on the un-intended consequences resulting from the actions and the automatic processes operated by public authorities, notably but not exclusively the Police Service. In addition, it must be highlighted that Kim identified the potential for trauma for the Police and ambulance service first responders. Where a traumatic critical incident has taken place, there is a need to maximise evidence and otherwise mitigate the negative impact on Criminal Justice outcomes, which if a balance is not struck can over-shadow or give a perception of not caring. Some examples of this include; 'bed watches' to gain evidence such as dying declarations and so not affording family members valuable personal time with an injured loved one, and the restricted access to Henry's body after he had passed away.

4.1.8 Kim has described the 'life changing' event and the trauma that she and her family members experienced as well as emergency services' first responders. It is therefore important to explore trauma briefly. Whilst definitions of trauma vary, broadly trauma refers to events or circumstances that are experienced as harmful or life-threatening and that have lasting impacts on mental, physical, emotional and/or social well-being. Trauma can be a single event or multiple events compounded over time. The Types of trauma are:
Type I trauma involves witnessing or experiencing a single event such as a serious accident, rape, homicide etc.
Type II trauma results from repeated exposure to extreme external events, such as ongoing sexual abuse.[68]

4.1.9 There is growing evidence of a link between trauma and mental ill-health, as well as people's experiences in the systematised approaches/responses used by public authorities, which can re-traumatise trauma survivors. For families of homicide victims this also includes 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. This is an experience the UK Government has recognised in its Victims Strategy, 2018.[69]

4.1.10 There is evidence that trauma informed approaches, practice or care are effective and can benefit the people involved e.g. victims, survivors and first responders. [70]

4.1.11 Fuller details of the impact experienced by Kim are documented in a victim impact statement, which is found in the appendices. The victim impact statement of Igor is found there.

---

[68] Sweeney, A., Clement, S., Filson, B. and Kennedy, A. (2016), "Trauma-informed mental healthcare in the UK: what is it and how can we further its development?", *Mental Health Review Journal*, Vol. 21 No. 3, pp. 174-192 accessed via https://www.emerald.com/insight/content/doi/10.1108/MHRJ-01-2015-0006/full/html
[69] HM Government, Victims Strategy, p19, September 2018 accessed via https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/746930/victim-strategy.pdf
[70] Sweeney, A., Clement, S., Filson, B. and Kennedy, A. (2016), "Trauma-informed mental healthcare in the UK: what is it and how can we further its development?", *Mental Health Review Journal*, Vol. 21 No. 3, pp. 174-192 accessed via https://www.emerald.com/insight/content/doi/10.1108/MHRJ-01-2015-0006/full/html

4.2 Recommendations

4.2.1 The recommendations below are, in the main, for the partnership agencies as a whole but organisations have identified internal recommendations that mirror or otherwise complement these. The single agency action plans should be the subject of review via the MK Together DHR Action Plan detailed below.

4.2.2 For reference the MK Together Safeguarding Partnership, chaired by the Milton Keynes Council's Chief Executive consists of the following agencies:

- Milton Keynes Independent Scrutineer
- Milton Keynes Council Adult Social Care
- Milton Keynes Council Children's Social Care
- Milton Keynes Council Public Health
- CNWL NHS Trust (Mental health and community health services provider)
- Milton Keynes University Hospital Foundation Trust
- Bucks Fire and Rescue
- Thames Valley Police
- National Probation Service
- Community Action MK
- Bedfordshire, Luton and Milton Keynes Integrated Care Board
- HM Prison Woodhill
- Oakhill Secure Training Centre

4.2.3 We recommend the following:

Local

Recommendation 1: That all agencies report progress on their internal action plans to the MK Together Safeguarding Partnership's 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 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: Thames Valley Police'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.[71] 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).[72]

This recommendation can be viewed in the context of the Right Care Right Person (RCRP) programme adopt across Police Forces including TVP.

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.

[71] Thames Valley Police's Mental Health Operational Guidance was updated at various time between April - December 2020
[72] Thames Valley Police's Mental Health Operational Guidance, para 3.18 (December 2020)

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 Thames Valley Police's Mental Health Operational Guidance.

This recommendation can be viewed in the context of the Right Care Right Person (RCRP) programme adopt across Police Forces including TVP.

Recommendation 5: That the MK Together Safeguarding Partnership, its constituent members and the wider partnership should consider the further enhancement of its whole family[73] practice approach to ensure that the support 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[74], 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.

[73] 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

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

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 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 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 Mental Health Trust, Milton Keynes (MK) Council and Thames Valley Police 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.[75] Such documentation is important to identify on-going healthcare needs as well as contributing to the Police custody risk assessment processes.

[75] Health based place of safety

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.

(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: Thames Valley Police 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.

<u>National</u>

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 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 Points Recommendations 16 and 17: 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.

Appendix 1: Domestic Homicide Review Terms of Reference for DHR 'Henry'

DHR Terms of Reference

These terms of reference describe what the DHR and multi-agency panel is doing in this statutory independent domestic homicide review (DHR).

We will:

- Identify what lessons may be learnt from the case focusing on the ways in which local professionals and agencies worked individually and collectively to safeguard victims to prevent future domestic homicides
- Determine how those lessons learnt may be acted upon
- Examine and where possible make recommendations to improve risk management mechanisms and system coordination arrangement within and between all the relevant agencies
- Identify what may be expected to change and within what reasonable timescales
- Assess whether the relevant agencies have appropriate and sufficiently robust procedures and protocols in place to identify, prevent, tackle and respond to domestic violence / abuse and the extent to which they are understood and adhered to by their staff and what should change if anything
- Improve service responses including by better understanding the overall "whole- system" needs of local people and where necessary, make changes to policies, practices, procedures and protocols
- Enhance the overall effectiveness of efforts to better identify, prevent and tackle domestic abuse and its impact on victims through improved inter and intra agency working
- Maximise opportunities for fast time learning and overall partnership improvements as well as well as medium – longer term sustainable enhancements
- Examine and make recommendations if appropriate to improve the accessibility of services to isolated communities including older people and those experiencing mental health problems.

By:

- Undertaking Individual Management Reviews (IMRs) in all organisations that were involved with the family and Glen between 1.1.2016 and XX.XX.2019 (actual date specified in ToR shared) dates and analyse those
- Whole systems need is based on whole systems thinking, that the parts of a system are all connected and, therefore, influence each other reports in terms of understanding what happened, why, where things went well, where things did not go well and what could have been done differently
- Taking into account any immediate learning and action arising from those IMRs then review the learning and, through an aggregated chronology, and joint discussions identify key lines of enquiry (KLOE) to explore further
- Interviewing family members, and any professionals as identified as particularly relevant to the KLOE and taking into account the interview records
- Taking into account learning from the NHS Serious Incident Processes, and the Safeguarding Partnership Local Learning Review
- Analysing the aggregated information and identify areas of strength in practice and areas where there is learning for the partnership system in Milton Keynes which will contribute to preventing similar incidents arising, and ways in which similar incidents could be managed differently as a partnership

The key questions we will initially focus on are:

- Were there signs or signals that Glen was potentially a risk towards his family members that were missed?
- Were there signs or signals that Glen was potentially a risk towards his family members that were identified but not responded to or communicated to others?
- Was it clear whether Glen when well still needed ongoing support, supervision and oversight or was he only involved with other services when unwell?
- Had agencies identified what Glen's ongoing needs were and was Glen receiving a coordinated level of service when well? Had they also identified whether Glen's family needed input or ongoing support?
- How well did agencies "see beyond" their immediate sphere of professional and legal requirements in order to address the whole situation for the family and local community as well as for Glen?

- Did any of Glen's family ask for help and support or express concerns outside the family about Glen being a threat to them at all. Did they discuss how he behaved towards them with others?
- Were professionals working with Glen aware of the signs and signals that could indicate there was a potential for domestic abuse or coercive control within the family?

The following overarching principles and approach describe how we are going to work individually and together to do deliver against the terms of reference.

We will:

- Recognise that the victim's family are a fundamental part of the DHR and that they are given the opportunity to contribute to and are involved in e DHR from its inception
- Ensure that the victim's family's voice is listened to and heard. Additionally, we will ensure that the victim's family are regularly updated with progress at agreed intervals by the DHR Chair
- Ensure that the DHR is conducted in professionally, effectively, efficiently and in a respectful way
- Be open, honest, transparent and respect the opinions and contributions of the panel members
- Work alongside the independent NHS England Reviewer and the Milton Keynes Council Independent Reviewer to add valued support to this statutory review
- Draw on the strengths, knowledge, skills and experiences of the multi-agency professionals in the DHR Panel / Coordinating Group.

Appendix 2: NHSE Level III Review Terms of Reference

Additional Draft Health Related Terms of Reference for Investigation into Care Provided for [Glen] Following the Death of [Henry].

The investigation will examine the NHS contribution into the care and treatment of the service users from his first contact with specialist mental health services up until the date of the incident.

Critically examine and quality assure the NHS contributions to the Domestic Homicide Review.

Examine the referral arrangements, communication and discharge procedures of the different parts of the NHS that had contact with the service user.

Review and assess compliance with local policies, national guidance and relevant statutory obligation.

Examine the effectiveness of the service user's care plan and risk assessment, including the involvement of the service user and his family.

Review the appropriateness of the treatment of the service user in light of any identified health needs/treatment pathway.

To work alongside the Domestic Homicide Review panel and Chair to complete the review and liaise with affected families.

To provide a written report to NHS England that includes measureable and sustainable recommendations to be published either with the multi-agency review or standalone.

Appendix 3: NHSE Level III Review Report

The NHSE Level III report included an Executive Summary (as required by that process). For the purposes of the DHR report the main report only is included.

Report Author: Anne Richardson, BSc MPhil FBPsS

Contents

EXECUTIVE SUMMARY

Independent review of mental health treatment and care provided by Central and North West London (CNWL) Mental Health NHS Foundation Trust

1. Introduction

1.1 This summary describes an independent review of care provided by CNWL for a patient, X, whose attack upon his elderly parents with a knife resulted in the death of X's father. We would like to extend our sincere condolences to X's family for their sad loss.

1.2 Our review was conducted in partnership with the panel established by Milton Keynes Safeguarding Board (MKSB) to undertake a Domestic Homicide Review (DHR). Our team is grateful to the panel for their help to elucidate the circumstances of the care provided for X. A full account of the approach taken by our team is provided in the full report which follows. Information is also provided there about our Terms of Reference (Appendix 1), the team (Appendix 2), a chronology of X's care is provided at Appendix 3.

2. Background

2.1 The primary care records indicate that X first reported symptoms of mental ill health (depression) to his GP in 2009 when in his thirties when he was prescribed an antidepressant. However, X himself subsequently reported to NHS staff that he had been depressed and anxious since he was a teenager which was when he also started using substances (alcohol, cannabis and solvents). X never married. He lived in the same street as his elderly parents and saw them frequently.

2.2 X was first admitted to psychiatric hospital for 9 months in 2016 first under Section 2 and then Section 3 of the Mental Health Act (these terms are explained in full in the main report) with what was described as a drug-induced psychosis. He had been taking cocaine and was floridly unwell. Following his discharge, X was supported by the CNWL Home Treatment Team (HTT). He was admitted twice more for very brief inpatient stays in December 2016 and January 2017, following which he was again supported in the community by the HTT and then the Early Intervention in Psychosis Team (EIPT).

2.3 X was last seen for a review by staff at the EIPT in November 2018. No change was reported in his mental state at this time, which remained good as far as symptoms of psychosis were concerned, and the notes record a conversation with X that he might benefit from doing some voluntary work. However, X then

failed to keep his next two appointments (in January and February 2019). The team tried to contact X but there was no response and, as plans had already been made to discharge him, further contact was not pursued.

3. The incident

3.1 In March 2019, police were called by neighbours to X's home owing to what appeared to be bizarre and violent (towards his property) behaviour. Police called an ambulance when it seemed that X was intoxicated, and he was taken to the Accident and Emergency Department. X was subsequently arrested for assault and a racially aggravated public order offence. Whilst in the A&E department X had a Urinary Drug Screen (UDS) which was positive for cocaine, cannabis, opiates, benzodiazepines and amphetamines. Unable to complete a formal assessment of X's mental state owing to his level of intoxication at that time, X remained in hospital overnight under observation. The following day, back in custody, X's behaviour became increasingly disturbed. Police therefore detained X under Section 136 of the Mental Health Act (MHA) and took him to the Campbell (mental health) Centre.

3.2 The experienced team, including staff who had previously known X, undertaking the MHA assessment did not judge that X was psychotic (i.e., suffering from a severe mental illness). Nor, at the time he was seen, did they judge X to be showing signs of risk to himself or others and he did not seem to lack insight or awareness. Therefore, the assessors did not judge X to be detainable under the Mental Health Act. He was diagnosed to have been suffering from mental impairment caused by substance-misuse which would resolve (or which had already started to resolve) as the drugs wore off.

3.3 When X was taken back into custody, his behaviour deteriorated once more. The healthcare professional at the police station called the duty mental health care team again. However, police were apparently advised that because X's behaviour had been assessed as drug-induced, they did not think it necessary to examine him again. X was therefore given access to a solicitor in the presence of an Appropriate Adult (his mother) and he was given medication. Without a legal reason to detain him further, X was released and taken home with his mother who was advised to call the police again if X's behaviour did not improve.

3.4 Later the same day, police received a call from the ambulance service to say that X's father had been attacked and was not breathing. When police attended, X's parents were both found to have received knife wounds and X was picked up nearby. The health care professional at the police station thought that X seemed delusional and thought disordered. Unable to be seen again at the Campbell Centre owing to the fact that the Place of Safety Suite was already occupied, X was taken to Aylesbury where he was, once again, assessed as unsuitable to be detained under the Mental Health Act. X was then remanded to prison where, over

the course of the next week, his behaviour worsened; he was then judged to be suffering from a psychotic illness. Later that year, after entering a guilty plea to manslaughter by diminished responsibility, X was sentenced to be detained indefinitely under Section 37/41[1] of the MHA.

4. Discussion of findings

4.1 A full account of the findings of the internal review completed by CNWL and of their evidence to the DHR is provided in the attached report. In summary, our team is content to report that we agree with the conclusions drawn by the Trust, and we note that steps have been taken to:

- Review policy and practice by the EIPT to ensure that patients who drop out of contact with services are followed up more assertively.
- Strengthen the way that mental health and substance misuse services are provided for patients with co-morbid mental health and substance misuse problems.
- Ensure that all parties involved in the administration of Section 136 of the MHA are aware of policy and practice and the means to secure an assessment.
- Implement the recommendations of the Rapid Review which was undertaken shortly after the incident.

5. Conclusion and recommendations

5.1 Our team did not judge that this tragic incident was predictable or preventable. It appears that X, 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. However, we have only been able to judge this with the benefit of hindsight. We did not find that the mental health team failed in their duty to assess and/or treat him prior to the incident although we did believe that there were ways services might be strengthened.

5.2 Our review also did not identify concerns over and above those highlighted in the Local Learning Review (the Rapid Review) that was undertaken during 2019, or concerns over and above those identified in the DHR. Furthermore, our team could see that some constructive improvements to strengthen services in the light of those recommendations have already started to be made by the Trust and

[1] **Sections 37/41 of the MHA cover respectively the "transfer" of a patient prior to sentencing from prison to a unit specializing in mental health treatment and the imposition of "restriction" to their detention such that the patient may not leave without permission from the Ministry of Justice.**

others. Although is still too early to assess the impact, we are confident that the improvements are targeted in the right areas.

5.3 We urge the Trust to review to review their Action Plan to incorporate all the recommendations arising from the Rapid Review listed in Appendix 4 and we urge the Trust to review its training for staff once their new procedures are in place. The aim is to ensure that information is always gathered from a wide range of potential sources (archived notes, police, family, A&E) as well as the patient to ensure that as broad a picture as possible is available. This can be particularly important when a crisis appears to be drug related and the clinical presentation is mixed. In this way, mental ill health that is apparently the result of or co-morbid with problems of substance misuse will not intentionally or inadvertently be excluded from care.

Independent review of mental health treatment and care provided by Central and North West London (CNWL) Mental Health NHS Foundation Trust

0. Introduction

6.1 This is the report of an independent review commissioned by NHS England and NHS Improvement (Midlands and East region) to review care provided by Central and North West London (CNWL) Mental Health NHS Foundation Trust (hereinafter called `the Trust') for X, a Trust patient who attacked his elderly parents in March 2019 with a knife; X's father died a few weeks later in April 2019.

6.2 We would like to extend our sincere condolences to X's family who have reported their distress in relation to what they judge to be shortcomings in the care provided for X when his mental health deteriorated.

6.3 The aim of reviews (known as NHS 'Level 3' reviews) such as this is to ensure that Serious Incidents are identified correctly, investigated thoroughly and, most importantly, learned from to prevent the likelihood of similar incidents happening again. In this case, the review was conducted alongside and in partnership with the panel established by Milton Keynes Safeguarding Board (MKSB) to undertake a Domestic Homicide Review (DHR).

1. Methodology

7.1 Appendix 1 contains a copy of the Terms of Reference (TOR) drafted for the DHR and for our team; the seven items relating solely to our NHS Level 3 review which was focused mainly on the NHS mental health Trust appear at the end. The TOR outline a requirement to understand the care and treatment provided for X from his first contact with specialist mental health services up until the date of the incident.

7.2 Appendix 2 contains details about our team consisting of an experienced consultant psychiatrist, a nurse with dual (general and mental health) qualifications and a clinical psychologist. The clinical psychologist attended meetings of the DHR panel and other team members were also involved in interviews and/or in formulating conclusions for the review

7.3 The team is grateful to the panel established to deliver the DHR, the Trust, the primary care team, and others for providing access to policy documents, case notes and other information. The Trust provided an initial investigation report (known as an NHS Level 2 report) commissioned by them and other material which helped our team to understand the extent and nature of the NHS mental health care that was provided for X, and the changes that have been made in services since. For example, we were able to access documents containing Trust policies on Care Planning, Risk Assessment and Early Intervention Team operations; information about changes in the commissioning arrangements for substance

misuse services and plans to strengthen communications and joint working with Thames Valley Police (TVP).

7.4 Our team was also able to see primary care records relating to the care provided by X and understand, because we had the benefit of participation in the DHR panel, how other services (such as substance misuse services, ambulance services and TVP) had been involved. The team is grateful for sight of a report of a Concise Learning Review (known as `a Rapid Review') that was carried out between the end of March and November 2019; this was designed to identify and help services to take action quickly in areas where improvements could be identified as needing to be made immediately.

7.5 Owing partly to the recency of the interviews undertaken with staff for the Level 2 review and to minimise the stress for them, it was agreed in an early meeting (October 2019) with a representative from NHS England and the Trust Service Director for Mental Health that our team would not repeat the interviews with staff unless reasons emerged later to make it necessary.

7.6 We learned that appropriate support had been provided to the staff directly who had been directly involved in X's care, and that a de-brief had been provided for the wider care team. We met personally with the Consultant Psychiatrist currently caring for X; the Trust's Safeguarding Adults and Mental Capacity Act Specialist; the GP and the Trust Mental Health Service Director. In all cases, information from those conversations was recorded and notes were sent for correction and/or approval prior to anonymised information being used to inform our conclusions.

7.7 A personal interview with X was also conducted in partnership with a representative of the DHR panel. However, our team did not have direct contact with X's family. It was agreed at the DHR panel that the Chair of the DHR panel would take responsibility for providing a Single Point of Contact (SPOC) for all communications with them. This was designed to remove the risk of duplication and reduce sources of potential stress and confusion for the family, given that several agencies were reviewing their own histories of contact with X.

7.8 We are aware that the Trust did make contact with the family at the outset of their Level 2 review, as is consistent with Trust policy. Support was also offered to the family by the Trust. However, it subsequently transpired that the Trust later contacted the family about sharing their report in April 2020, the first anniversary of X's father's death. The team understands that the Trust has apologised for this.

8. The Incident

8.1 Just before 1.00 pm on [date of the incident], the police received a call from the ambulance service to report that X's father had been attacked and was not breathing. When police attended the house, X's parents were both found to have

received knife wounds and X was picked up nearby. He was seen in custody by the health care professional at the police station who thought that X seemed delusional and thought disordered. Further details about the communications between and steps taken by NHS and criminal justice systems staff are provided below.

8.2 What follows is a chronological narrative account of events including contextual information about services. An abbreviated chronology may be found in Appendix 3. It is informed by the NHS primary and specialised care electronic case notes and the Trust Level 2 report. More detail about all the services having contact with X may be found in the DHR report, consistent with its broader remit.

9 Background

9.1 X was born in early 1970s and left school in1989. Over the course of his adult life, X worked as a landscape gardener; he worked overseas; had at least one significant relationship and owned his own house in the same street as his elderly parents whom he saw regularly. X did not reportedly have very much contact with his older sister. He did not marry and has no children. NHS records show that, over the period of his adult life, X got into financial difficulties, partly owing to the fact that he was the victim of a business scam, and partly because he spent a significant amount of money on substances (cocaine, alcohol).

First mental health presentation

9.2 The primary care records indicate that X first reported symptoms of mental ill health (depression) to his GP in 2009 when in his thirties when he was prescribed an antidepressant. However, X himself subsequently reported to NHS staff that he had been depressed and anxious since he was a teenager, which was when he also started using substances (alcohol, cannabis and solvents).

9.3 Records also show that X had been found to be exhibiting bizarre behaviour when he came to the attention of the Police in 2000 and 2006 for (respectively) getting into a fight and for altercation(s) with neighbours although there is no indication that mental health services were involved at this time.

9.4 Between 2013 and 2015/16 there was no evidence that X met specialised mental health services although records do show that he visited his GP for support to manage symptoms of anxiety and depression. In October 2013 X was also referred for counselling/psychological therapy (the `IAPT[2]' service). However, he was not accepted for treatment, it being considered that substance misuse services would be the more appropriate place for him to be seen.

[2] Improving Access to Psychological Therapies (IAPT) is an NHS service located in the community working in partnership with primary care to deliver brief, evidence-based interventions for people with so-called `common mental disorders' such as anxiety and depression. People with severe mental ill health would normally not be seen by IAPT staff.

Substance misuse services

9.5 Substance misuse services in Milton Keynes were at that time in 2013 managed by CRI (Crime Reduction Initiatives), part of the local authority, and they provided recovery focused treatment for people experiencing drug and alcohol dependency. According to the GP records, X was reluctant to seek help from them.

9.6`Compass', commissioned by Central Bedfordshire Council, took over management of the substance misuse service in 2017. Compass was described by the Care Quality Commission as offering a range of support groups, one to one key working; medically managed alcohol detoxification; substitute prescribing for opiate detoxification for adults, a needle exchange clinic and blood borne virus testing. It did not appear from the NHS records that X was keen to be seen by Compass either although his GP and representatives from specialised services had frequently encouraged him to.

First psychiatric admission June –September 2016 (S 136, S.2 and S.3 of the MHA)

9.7 In early June 2016 X telephoned the Police as he thought someone had broken into his house. However, he was found to be behaving irrationally and a few days later in June 2016 he was taken to A&E by ambulance having had a seizure during a GP appointment. X then discharged himself from A&E, pulled the cannula out of his arm and was found by neighbours who called the police to be behaving bizarrely and causing a disturbance.

9.8 X was taken to the Campbell (mental health) Centre that evening (in June 2016) and was admitted and diagnosed with a drug-induced psychosis the following day. It is not clear from the records whether, after 2 days in June 2016, X discharged himself or was discharged, but he was brought back by the police the next day under Section136 (S.136) of the Mental Health Act (MHA) and he remained in hospital for just over three months, first under Section 2 and then Section 3[3].

9.9 Whilst an inpatient, X was diagnosed with cocaine intoxication. He was floridly unwell: he was described as having haptic hallucinations (such hallucinations are not uncommon in drug toxicity; they involve the sensation of touch), and persecutory delusions. X was physically aggressive, smeared faeces on the walls and drank his own urine; he was over-familiar with staff and peers, aggressive and sexually disinhibited, erratic, disinhibited, spitting, and he stripped off his clothes.

[3] S.136 of the MHA is an emergency power which allows a police officer to take someone (for a maximum of 72 hours) to a place of safety if there is concern that the person has a mental disorder and should be seen by a mental health professional. S.2 of the MHA permits someone to be detained for up to 28 days for assessment and S. 3 permits detention for up to 6 months for treatment.

X spent 2 days in a Psychiatric Intensive Care Unit (a PICU which is a locked ward) owing to the difficulty of managing this behaviour on an open ward.

9.10 X was discharged after three months in September 2016 with a prescription of Olanzapine 5mg daily (an anti-psychotic) which was later changed to Aripiprazole 10mg daily and then in October to Risperidone 1mg at night. He was also given Sertraline (an anti-depressant) and Zopiclone (to help him sleep). X was supported initially by the Home Treatment Team (HTT) and then by the Early Intervention in Psychosis Team (EIPT).

Second and third brief admissions (informal: in December 2016 and in January 2017)

9.11 X was admitted briefly on two further occasions: once for two days just before Christmas 2016 when he was reportedly depressed and had thoughts about harming himself, and the other for one night in early January for similar reasons.

Support in the community 2016/17 – 2018

9.12 Between 2016 and 2018 X was in regular contact with representatives of the Home Treatment Team (HTT). He was referred to the Citizen's Advice Bureau for help with financial difficulties. X had a care plan, a care coordinator and his physical health was checked and monitored. Risk assessments were completed; he had a Mental Capacity Assessment, and his care plan was regularly reviewed.

9.13 In total, 25 visits were made by the HTT between December 2016 and February 2017, after which, X was transferred to the care of the Early Intervention in Psychosis Team (EIPT). Between February and September 2017, the EIPT saw X 22 times; his mental state was described as having improved significantly and X reported to them that he was not using illicit drugs. According to the Trust case notes, X's parents attended a care plan review meeting at the end of September 2017 when this was summarised and discussed.

9.14 Between December and June 2018, X was seen 9 times by the EIPT and, as all appeared to be going well, from March 2018, his antipsychotic medication (Risperidone) was stopped. From June 2018, it was also agreed that X no longer needed to be managed under the Care Programme Approach[4] (CPA). X said he had not had any psychotic symptoms since 2016 and was not using illicit drugs, although he reportedly still had difficulties with his mood and sleep, for which he was given appropriate medication. Communications were maintained with X's GP,

[4] The Care Programme Approach or CPA Is a framework for the provision of care to people with mental health problems in contact with specialised mental health services. The framework sets out how care plans should be written to show what treatment is being provided and reviewed regularly. Risk assessments normally form part of CPA.

and attention was given to assess and help him monitor his physical health (X's weight was too high and he had a high level of cholesterol).

9.15 X was last seen for a review by staff at the EIPT in mid-November 2018. No change was reported in his mental state at this time, which remained good as far as symptoms of psychosis were concerned, and the notes record a conversation with X that he might benefit from doing some voluntary work. However, X then failed to keep his next two appointments (in January and February 2019). The team therefore telephoned X, they sent him a letter, and they telephoned X's mother but there was no response from either. Other records indicate that X's father (in his 80s) was becoming increasingly frail by this time. X subsequently reported that he failed to keep his appointments because he was fearful that EIPT staff would restrict his access to repeat prescriptions of diazepam from the GP, although it is not clear that he was correct in this belief.

Events leading up to the incident

9.16 On the specified date in March 2019 X's neighbours called the Police because X was smashing up his house, breaking windows and was allegedly in possession of an air rifle. When Police arrived, X was seen to be behaving in a sexually inappropriate and racially abusive way. Police called an ambulance when it became clear that he had been taking drugs and seemed to be suffering from a psychotic illness; X was taken to the Accident and Emergency Department and subsequently arrested for assault and a racially aggravated public order offence.

Accident and Emergency Department (A&E two dates in March 2019)

9.17 Whilst in the A&E department X had a Urinary Drug Screen (UDS) which was positive for cocaine, cannabis, opiates, benzodiazepines and amphetamines. Unable to complete a formal assessment of X's mental state owing to his level of intoxication at that time, X remained in hospital overnight under observation. Because the ambulance service and the acute hospital do not use the same client record system as the Trust and Primary Care, X was not immediately identified as being a current patient of the Trust. Furthermore, it is not exactly clear from the records when X was referred for mental health assessment. In relation to both these points, the Rapid Review report identified a need for clarity and strengthening of the knowledge amongst agencies external to the Trust for accessing mental health care.

Police station, later in March 2019

9.18 The following Saturday morning in March 2019, as X attacked an officer, and had threatened to rape a member of A&E staff, he was arrested and taken back into police custody. At the police station, X reportedly took a shower but started to

smear faeces on the wall of the cell. Police therefore detained him under Section 136 of the (MHA). Records show that the Out of Hours Social Care Service received a referral for a section 136 assessment and that Police took him to the Campbell (mental health) Centre for a Mental Health Act Assessment.

Campbell Centre Section 136 suite, specified date in March 2019

9.19 On arrival at the Campbell Centre 136 suite[5] - the local NHS based `Place of Safety' - at around 11.00 am on the Saturday in March 2019, X's mood was reportedly elated. The on-duty Approved Mental Health Professional (AMHP) did not appear to have advance warning that X was going to be taken to the health-based place of safety, but proceeded to arrange a MHA Assessment. At 1345hrs the AMHP contacted the psychiatrist on call. Owing to the fact that he was located some distance away, the psychiatrist asked for another duty doctor to be approached, a normal request in the circumstances. When X was seen, he did not show signs of aggression although his behaviour was socially inappropriate; he tried to hug the nurses and he appeared excitable and overfamiliar. A MHA Assessment was completed just after 3pm by two doctors and an Approved Mental Health Professional[6] (AMHP) at the Campbell Centre. A member of the Acute Home Treatment Team who knew X was also present.

9.20 It was the opinion of the experienced team who assessed X that he was not suffering from a psychotic illness, and they did not judge that it would be appropriate to detain him. They concluded that X had been suffering from the effects of taking cocaine and was now `completely rational;' his mood was normal, he was not psychotic and it appeared that his behaviour was due to the effects of taking illicit substances. X was offered a referral to substance misuse services, which he declined, and he was advised to get back in touch with the EIPT with whom he had previously been in contact, although he had not been seen since by them since the previous November. The AMPH then contacted X's care coordinator and passed on information about the MHA Assessment.

9.21 Detailed information about the MHA Assessment was not passed on to the police and X was released from his Section 136 at 15.50 on the Saturday in March 2019. He was taken back into police custody because of the charges levelled the day before. The Rapid Review report suggested in another learning point that the process of handover between agencies should be strengthened.

---

[5]Section 136 of the MHA permits the police to remove a person from a public place when they appear to be suffering from a mental disorder and take them to a place of safety. The Section 136 suite is an appropriately equipped and staffed place of safety where an assessment under the MHA can be completed.

[6] An AMHP is a clinical professional (e.g., an approved social worker, registered nurse, or practitioner psychologist) who has been trained to exercise functions under the Mental Health Act 1983to assist in decisions about individuals with mental disorders, including the decision to apply for compulsory admission to hospital.

Return to the police station, specified date in March 2019

9.22 When X got back to the police station he began, once again, to behave in a disturbed way. Police records show that he defaecated on the floor of the cell and wiped faeces on his face and the cell wall. The healthcare professional at the police station called the duty mental health care team again. However, police were apparently advised that because X's behaviour had been assessed as drug-induced, they did not think it necessary to examine him again. X was given access to a solicitor in the presence of an Appropriate Adult (his mother) and he was given medication. Without a legal reason to detain X further, he was released just after midday the next day - a Sunday in March 2019. X and his mother were taken to X's parents' home and X's mother was advised to call the police again if X's behaviour did not improve.

9.23 Just before 1.00 pm on the 'specified date in March 2019, the police received a call from the ambulance service to report that X's father had been attacked and was not breathing. When police attended, X's parents were both found to have received knife wounds and X was picked up nearby. He was seen in custody by the health care professional at the police station who noted that X seemed delusional and thought disordered.

9.24 X reported subsequently to the team that he had not been himself on that day because he had `taken cocaine every day for the previous 9 months.' He later reported thinking that the cocaine he had taken (which, if X's self-report is accurate, he would have to have taken it after he was released into his parents' care) would not hurt him. He said he was `not being psychotic or anything'. However, he had `not felt like that before'. He said he did not normally feel angry on drugs. X said that he was worried about his mum. He said his dad was dying and that he himself felt ill. X also explained that his mum `worries about everything' and he explained that he originally went to get knife to kill himself but as he knew it `would destroy his mum' if he did, he thought he would kill them instead. X also described having a range of visual hallucinations at this time.

9.25 A referral for a MHA Assessment for X was made by police at 15.20 on the date in March 2019 referred to in 9.23 but at 18.00 a call was received by the worker on duty that an assessment would not be undertaken at the police station (this advice is consistent with guidance in the MHA Code of Conduct) and it was reportedly said it would be preferable that X appear before the Court and/or have a forensic assessment in view of the nature of the incident. The custody sergeant escalated this decision with more senior staff at the Trust and at 21.53 X was taken to the Campbell Centre although, when they got there, they could not access the S.136 suite because it was already occupied. X was therefore taken to the Whiteleaf Centre in Aylesbury (managed by a different mental health Trust) and he was assessed there; this

arrangement is consistent with Trust policy at CNWL and in Oxford which carries responsibility for the Whiteleaf Centre for occasions when the CNWL Place of Safety cannot be accessed.

Whiteleaf Centre same date in March 2019 as that referenced in 9.23

9.26 When X was assessed at the Whiteleaf Centre under the MHA he was seen by two consultant psychiatrists and an AMHP who were not familiar with his history. The police record states that (aware of the alleged offence) the assessing team judged X not to be psychotic or detainable under the MHA. The assessing team allegedly told police that they were `reluctant to fully explore X's mental state or discuss the alleged offence' given that a death had occurred and that they thought X should be returned to custody to be assessed by forensic experts. X was then remanded to prison. Our team does not judge this decision to have been inappropriate.

Prison same date in March 2019 as that referenced in 9.23 and above

9.27 X's behaviour deteriorated rapidly over his first week in prison: he began to appear thought-disordered and bizarre in his conversation and behaviour. He was transferred to the clinical assessment unit at the prison where he behaved in an abusive manner to staff, ripped up several mattresses, smeared and ate faeces and drank his own urine. He was started on a dose of anti-psychotic medication (Risperidone 4mg daily) and a relatively high dose of an anti-depressant (Venlafaxine 375mg). X was referred to and then assessed by a Consultant Forensic Psychiatrist from the local Medium Secure Unit who judged X at that time to `more likely than not to be psychotic'. X was then transferred from prison under Sections 48 of the MHA to a Medium Secure Unit (MSU).

Medium Secure Unit Mid-April 2019 – present

9.28 Initially, X was nursed in the Medium Secure Unit (MSU) Long-Term Segregation Unit on Level 4 observations[7]. It was the Consultant Forensic Psychiatrist's opinion that his symptoms met criteria for Schizo-Affective Disorder Manic Type. This was because X presented with persecutory ideas, auditory hallucinations, passivity phenomena and thought disorder. His mood was reportedly elevated. X was also periodically described as depressed and was irritable and sometimes aggressive towards staff. X also occasionally reported thoughts of self-harm and in late May 2019 he attempted to strangle himself with string from his tracksuit bottoms. By mid-July 2019, X's medication consisted of an

[7] Levels 3 and 4 are commonly referred to as `constant' observations of a patient by a member of staff. The member of staff remains within arm's length at all times, day and night.

anti-psychotic: Risperidone 6mg BD (twice daily), and anti-depressant: Venlafaxine 150mg BD and a sedative: Lorazepam 1-2mg per day if it was needed.

9.29 X's future plan was described in the minutes of a CPA meeting held at the MSU in mid-July 2019 as consisting of sessions with the psychologist (whom he said he'd had an impulse to hit); `stabilisation work' to help him resist urges to harm himself and to reduce the risk of suicide; preparation for transition to a less restrictive ward environment; engagement in the ward community (groups and meetings) and maintenance of contact with his family, if and as appropriate. In addition, X would be encouraged to attend Occupational Therapy and work to reduce his weight.

9.30 In August 2019, after entering a guilty plea to manslaughter by diminished responsibility, X was sentenced to be detained indefinitely under Sections 37 and 41[8] of the MHA. At the time of writing, no date has been set for an Inquest into the death of X's father although a date in September is currently being anticipated for a Pre-Inquest Review (PIR), delayed owing to Covid-19 restrictions.

10 **Discussion of findings**

10.1 In this section, information is presented in relation to the seven terms for the NHS Level 3 review that are appended to the TOR agreed for the DHR (Appendix 1). Inevitably, these terms overlap slightly and, where appropriate, they have been considered together.

***Critically examine and quality assure the NHS contributions to the Domestic Homicide Review*.**

10.2 The Trust initially completed a Root Cause Analysis and Level 2 review of the care provided by the Trust. In addition, the Trust provided an Individual Management Review (IMR) for the DHR. The Level 2 report and the IMR were submitted to the DHR team and to our team, with the former having been signed off by the Clinical Commissioning Group on 25 March 2020. The Level 2 report concluded that the tragic incident that resulted in X's attack upon his parents could not have been predicted or prevented.

10.3 Our team is of the view that the IMR and the Level 2 review broadly met their terms of reference in outlining the circumstances of and the care provided for X by the Trust although there are some small inaccuracies in the Level 2 report regarding dates which have now been fed back to the Trust.

[8] Sections 37 and 41 of the MHA cover respectively the "transfer" of a patient prior to sentencing from prison to a unit specializing in mental health treatment and the imposition of "restriction" to their detention such that the patient may not leave without permission from the Ministry of Justice.

10.4 The Level 2 report also has a relatively narrow focus (nonetheless consistent with the TOR that usually govern such reports) in that it mainly dealt with actions taken by Trust staff and their clinical decisions rather than the wider picture of interagency communications and partnership working which provide a focus for the DHR. It makes only one recommendation (beyond two that apply to all such reports about sharing findings) for the EIPT to `review their policy for clients who do not attend appointments.' Our team does not disagree with this recommendation which should prove helpful for the service in the long run. However, our team does not believe that the EIPT acted inappropriately and more information about this is provided below.

10.5 Our team is content to report that the Trust's contributions to the DHR are broadly appropriate.

Examine the referral arrangements, communication and discharge procedures of the different parts of the NHS that had contact with the service user.

10.6 Our team received very positive feedback about the referral arrangements and communications between primary and the Trust specialised mental health services. Unusually, and very helpfully, the two services share access to a single electronic case records system. However, it is less clear that all those who may need it can readily establish what may be essential information about a patient who has a history of contact with mental health services. Although there is a Mental Health Liaison Team located in A&E who would be able to access the information if they were contacted, we support the recommendation made as part of the Rapid Review (see Appendix 4) which urges the Trust and other agencies to explore means to improve communication about how to do this.

10.7 Our team did not consider that the EIPT acted inappropriately when X missed two appointments in early 2019, although we agree that they might have done more. The EIPT tried to contact X by letter and telephone, and they left a voicemail message for his mother. Communications were also in place at that time about X with the primary care team who were providing X's prescriptions, and it was known that plans were being made towards the end of 2018 to `step down' X's care to support him through what is known as `Primary Care Plus' which provides more counselling, psychological therapies and other services than are available from the GP alone.

10.8 We note that since the time of this tragic incident, the EIPT Operational Policy has been reviewed. In a copy dated March 2019 there is reference to how or whether the team should follow up a patient who fails to attend. The policy states:

> `*When the individual meets the criteria for the EIS, however does not wish to engage and all efforts to engage with the individual are exhausted, CPA review and appropriate sign posting to primary care should be undertaken. Risks*

should be identified, documented and actively managed as far as possible. Decisions about discharge of these individuals should be undertaken at the weekly MDT team meeting and communicated to services involved. Prior to discharge, if face to face or telephone contact cannot be made, a letter will be forwarded to the service user requesting them to make contact with the service within 14 days. If no response is obtained, a discharge letter will be sent to the GP and the service user as per normal processes'

10.9 Our team believes that this will help to ensure, in future, that more assertive follow-up is provided by the EIPT.

10.10 In considering referral arrangements, communications and discharge procedures, our team also explored the complex pattern of problematic communications around X's detention and the two referrals for a Mental Health Act Assessment that were made by the police on two dates in March 2019. On the first date in March 2019, X was seen for a MHAA at the Campbell Centre S.136 suite. This assessment appears to have been thorough: X was not deemed to be psychotic and although an informal admission was apparently discussed and thought not to be appropriate, X was not thought detainable under the MHA. Alternatives (contact with EIPT, and substance misuse services) were suggested.

10.11 However, the second referral the following day, when X's behaviour deteriorated significantly once again, was allegedly refused on the grounds that X had already been seen. Police were allegedly told that because X's behaviour was drug-induced a further mental health assessment would be inappropriate, and it was allegedly suggested that X should be presented to the Court and assessed by a forensic expert. After this, after several telephone calls, and when it became clear that the S.136 suite at the Campbell Centre was busy, police were obliged to take X to be assessed under the MHA in Aylesbury (provided by a different Trust).

10.12 Our team considers that it would have been helpful if the Level 2 had explored further the criteria for acceptance for a re-assessment (whether or not in relation to the MHA) and if it had considered the importance of inter-agency communications about referral criteria in challenging circumstances like these. The Level 2 report simply says `It is noted but does not form part of this investigation that Patient A [X] was further assessed under Section 136 in the Whiteleaf Mental Health Centre in Aylesbury in the early hours of a date later in March 2019 and assessed as not meeting the criteria for detention.'

10.13 In the experience of our team, it is not uncommon for mental health and substance misuse services provided by different organisations to find it challenging to agree where the boundaries lie, or they find it difficult to share information and work in partnership. It can be especially difficult for people with co-morbid substance misuse and mental health problems (`dual diagnosis') to navigate the care pathway when/if there are `boundary' disputes as there may be between mental health and substance misuse services, general and forensic mental health,

or services for people with personality disorder rather than mental illness per se. It can be especially difficult for families and carers or external referrers to understand why an admission to psychiatric hospital may be thought inappropriate when someone presents with the level of bizarre behaviour that X displayed.

10.14 The Level 2 report offers no discussion of this point but we are informed that it would not be policy to exclude anyone with a severe mental health problem even though it is the case that patients with purely drug-induced temporary symptoms would now fall outside the EIPT remit[9]. Substance misuse was clearly identified as a risk factor in X's Risk Assessment and relapse profile; he had been admitted in these circumstances in 2016 (information about this was readily accessible and one of the medical assessors knew X from that time). X had also previously been under the care of the EIPT lending credence to the view that a psychotic illness of a more enduring nature had already been recognised.

10.15 Our team notes that policy on making a referral under S.136 of the MHA have now been reviewed, clarified and re-distributed following a recommendation in the Rapid Review report. We have also seen an (as yet unsigned) Memorandum of Understanding dated October 2017 between `Thames Valley Police and Mental Health Establishments in the Milton Keynes Local Police Area'. Although this helpfully focuses on occasions when mental health staff may need to call for help from the police, it does not address concerns on the occasions when police seek help from them. Our team fully supports the five recommendations (1, 4, 5, and 6) made in in the Rapid Review which relate to these areas.

Review and assess compliance with local policies, national guidance and relevant statutory obligations.

Examine the effectiveness of the service user's Care Plan and Risk Assessment, including the involvement of the service user and his family.

10.16 Our review of case notes and conversations with staff and also with X himself suggest that the Trust provided a good level of care for X in the period between 2016 and 2018 when he dropped out of contact with the EIPT. Care plans and Risk Assessments were completed in full, and X and his parents were informed and involved. All these elements of care were delivered in accordance with local policy, national guidance and the Trust's statutory obligations.

10.17 Although the Trust was broadly unaware that X had contact with the Police prior to 2016 (and NHS services do not have a right of access to police records so they could not have known this unless X told them), the Trust was aware of X's drug and alcohol misuse, and this was clearly identified as a risk factor in the Risk Assessment. X knew who to call in an emergency and he spoke warmly about his care coordinator.

[9] The Trust policy for EIPT operations dated March 2019 EIPT explicitly excludes patients with `first episode psychosis with a primary organic cause'.

10.18 It is also clear that the Trust was aware that X depended upon his elderly parents for support, and we could see from the notes that an appropriate question about safeguarding was raised as part of X's Risk Assessment. The Trust records show that at the time they were in contact with X they were not able to identify risks to X's parents' safety. Indeed, during discussion with X, he identified his parents (and his cats) as factors mitigating his periodic thoughts of suicide. Our team also notes that the Trust has reviewed and amended the referral form used to make safeguarding adults' referral.

Review the appropriateness of the treatment of the service user in light of any identified health needs/treatment pathway

10.19 X appears to have been provided with appropriate treatment at all stages of his contact with the Trust until the incident occurred in 2019. When a drug-induced mental health crisis occurred in 2016, X was admitted for three months. He was then admitted briefly on two further occasions as an informal patient (in December 2016 and January 2017). He was treated with appropriate medication; given advice; opportunities were offered for onward referral (e.g., to psychology, substance misuse services, Citizens Advice, voluntary work), and his physical health was monitored appropriately.

10.20 When X presented once again in 2019, having been brought in by the Police, he was seen at the Campbell Centre by an experienced team who completed a MHA Assessment; symptoms of psychosis were not present when the team saw him, although it does appear that they were present before and afterwards. Although it will be difficult for non-experts to understand, it does not appear to our team that the assessment was flawed. Symptoms can fluctuate and, when X was seen, it is clear that detention under the MHA would have been unlawful. However, it is always important to take a wide view and solicit information from others (e.g., family, police, A&E) to inform the decision.

10.21 We urge the Trust and the local authority to review their training for staff to ensure that information is always gathered from a wide range of potential sources (archived case notes, police, family, A& E) to ensure that as broad as possible an assessment is made when someone presents or is referred in a mental health crisis. This is always important but when the crisis appears to be drug-related, or when the clinical presentation fluctuates and/or if symptoms do not wear off when the drug does, there is a need to appraise all circumstances very carefully.

10.22 We note that from April 2020 new arrangements are in place for the provision of support and treatment for people with substance misuse problems and/or mental ill health. Funding for new staff, clinical, governance and organisational arrangements have been identified and although it is too early to assess the impact, our team would be optimistic that this will help significantly to prevent patients with dual diagnosis from falling through the net. Our team does not judge

it appropriate to make additional recommendations beyond those in the Rapid Review with which we agree (also reflected in the overarching report of the DHR).

11 **Conclusion and recommendations**

11.1 This is the report of an independent review commissioned by NHS England and NHS Improvement (Midlands and East region) to review care provided by the Trust for X, a Trust patient who attacked his elderly parents in March 2019 with a knife; X's father died a few weeks later on (date removed). The review was conducted alongside and in partnership with the panel established by Milton Keynes Safeguarding Board (MKSB) to undertake a Domestic Homicide Review (DHR). Their report will be available separately. We are grateful for the benefit of working with and alongside the DHR panel whose insights and the opportunity for working in partnership with all stakeholders proved invaluable.

11.2 Our team did not judge that this tragic incident was predictable or preventable. It appears that X, 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. However, we have only been able to judge this with the benefit of hindsight. We did not find that the mental health team failed in their duty to assess and/or treat him prior to the incident occurring, although we did believe that there were ways in which the service could be strengthened.

11.3 Our review also did not identify concerns over and above those highlighted in the Local Learning Review (the Rapid Review) that was undertaken during 2019, or concerns over and above those identified in the DHR. Furthermore, our team could see that constructive improvements to strengthen services in the light of those recommendations have already started to be made by the Trust and others. Although is still too early to assess the impact, we are confident that the improvements are targeted in the right areas.

11.4 Our sincere condolences are extended to X's family who lost a husband and father after X attacked his parents with a knife in what appears to have been a psychotic illness exacerbated by cocaine abuse.

APPENDIX 1: NHSE Level III report

DHR Terms of Reference – can be found at appendix 1 of the DHR Overview Report.

APPENDIX 2: NHSE Level III report

Investigation team

Anne Richardson, BSc, MPhil, FBPsS, Director of ARC, is a clinical psychologist by training. She specialised in clinical work with adults with severe mental ill health and long-term needs. She is an experienced teacher/trainer and communicator, having worked as joint Course Director of the DClinPsy at UCL before moving to take a post at the Department of Health. Subsequently, as Head of mental health policy at the DH, she was instrumental in the development and delivery of the National Service Framework for Mental Health and, with Sir Jonathan Michael, led development and delivery of the national learning disabilities inquiry `Healthcare for All' (2008).

Hugh Griffiths, MBBS FRCPsych, is a former consultant psychiatrist in the North-East of England where he carried responsibility for inpatient and community psychiatry for adults, recovery and rehabilitation for people with severe and long-term mental disorders, and liaison services in general hospitals. As Medical Director of the Northern Centre for Mental Health he was responsible for the development of guidance on changing roles for consultants, support for medical managers, and clinical leadership of the Mental Health Collaborative. Latterly, as National Clinical Director for Mental Health (England) at the Department of Health, he led the development of the Government's Mental Health Strategy "No Health Without Mental Health" (2011) and was instrumental in its subsequent Implementation Framework. He retired from this post in March 2013 and now works as a non-Exec in a mental health trust in the north of England.

Adrian Childs RMN, RGN, DipN (Lond), MSc, Dip Exec Coaching, trained as a general and mental health nurse. He was director of nursing at Newcastle, Northumberland and North Tyneside Mental Health Trust; he holds a diploma in leadership, mentoring and executive coaching. Adrian has contributed to several national working parties including the development and appointment of Consultant Nurses and development packages for nurses working with severe personality disorders. His most recent post was as director of nursing at Newcastle, Northumberland and North Tyneside Mental Health Trust. In 2014 Adrian was made Honorary Professor for the Faculty of Health and Life Sciences at De Montfort University, Leicester.

APPENDIX 3: NHSE Level III report

Chronology of NHS care

DATE	EVENT
Date unspecified	X reported to staff that he had taken overdoses as a teenager and that he started using drugs when he was a teenager.
Mid-May	X (in his twenties) was arrested following a fight in a bar but not charged.
Beginning	X was diagnosed with and treated for ulcerative colitis. This was also the year X subsequently reported that he split up from his girlfriend.
Mid-June	Calls were made to the police by neighbours who complained of disorderly behaviour by X. X behaved very bizarrely (barking like a dog in the street, verbally abusive, etc) He was given a fixed penalty notice for disorderly conduct. The problem, evidently quite severe, persisted and X was given a bail condition that he should not live at the address. He was found guilty of harassment and fined.
End of	X was seen by his GP complaining of depression, anxiety and poor sleep. He was given a prescription for Citalopram (an anti-depressant)
End of	X was seen by his GP with mixed anxiety and depressive disorder. He was known to be using cocaine twice weekly and drinking a bottle of wine per night. He was started on Fluoxetine (an anti-depressant); referred to IAPT (a service providing access to `talking treatment' for common mental disorders) and given advice about substance misuse.
End of October	The referral to IAPT was rejected on the grounds that X would more appropriately be treated by substance misuse services (CRI).
2014	X subsequently reported that 2014 was the last year he ever went fishing or hunting. He said he was very isolated and a bit lonely. His mood, he said, was very low. He had not talked to anyone about his mood. He would spend most evenings at home entertaining himself with a bottle of wine and with coke.
2013-2015	No evidence of contact with specialised services although records show that X visited his GP for support to manage symptoms of anxiety and depression.
Early June	X telephoned the Police but was found to be behaving irrationally; he thought someone had broken in.
Three days after the above incident in 2016	X was taken to A&E by ambulance having had a seizure during a GP appointment. However, he self-discharged before being seen. X's neighbours then called the police as X was creating a disturbance in the street and he was later found by police having pulled the cannula out of his arm and behaving bizarrely. He was taken to the Campbell Centre that evening.
One day after above incident,	X's mother reported concerns to the GP about her son: they had not been able to locate him over the weekend & his behaviour had seemed unpredictable.
Over a	X was admitted to the Campbell Centre for 2 days after being picked up twice and assessed by the MK Street Triage Team. He was diagnosed with a drug-induced psychosis. He then either discharged himself or was discharged after 2 days. The TVP record says X was discharged `because he was deemed not to be mentally ill – behaviour is drug-induced'

	X subsequently reported that he had money worries prior to this first admission His house sale was slow going through – had been waiting for 9 months and had no money. Had been working at his sister's landscaping business.
Early June 2016	X was brought back by police the next day on S.136 and in handcuffs owing to his aggressive behaviour. He was floridly unwell: erratic, disinhibited, spitting, and stripping his clothes off. He had hallucinations (tactile), persecutory delusions; he smeared faeces on the walls and drank his own urine. He was over-familiar with staff and peers, aggressive and sexually disinhibited. He spent 2 days in a PICU (locked ward) on Section 2 of the MHA owing to this behaviour and in July this was converted to a S.3. X was diagnosed with cocaine intoxication. Records show that the Risk Assessments were updated 11 times this month; they identify risk factors (drugs) and protective factors (his cats, his parents) and they mention X's worry that he does not know how he'd cope without his parents.
End of July 2016	X was referred to and accepted by the Early Intervention in Psychosis team who would be providing support, along with the Home Treatment Team, after admission. This month, he had a formal Mental Capacity Assessment and a thorough check of his physical health. X's care plan was reviewed four times in July. He was also referred to Citizens Advice Bureau for help with his financial difficulties.
Early	X was discharged on Olanzapine 5mg daily, which was later changed to Aripiprazole 10mg daily and then in October to Risperidone 1mg at night (anti-psychotics). He also had Sertraline (anti-depressant) and Zopiclone (for sleep
Mid-	X was listed as under the care of the Early Intervention in Psychosis team (EIPT) and the Home Treatment team after his discharge.
In October	X attended a care planning review
Later later in February	In total, 25 visits were made after Christmas by the HTT before X was referred back to the EIPT in February. Several visits were also made jointly between the HTT and EIPT.
Mid-	X was re-admitted for 2 days to Hazel ward with depression.
Early	X was admitted again overnight owing to having reported suicidal thoughts.
Later in January 2017	X failed to keep an outpatient appointment. He also reported that he was not finding psychology sessions helpful.
Feb- Sept 2017	EIPT saw X 22 times; his mental state was described as much improved and he seemed better organised at home. X did not report thoughts of wanting to harm himself or others. His physical health was monitored and his medication updated.
Late September 2017-	CPA meeting – family also involved. CPA and Risk assessment paperwork completed. X reported no psychotic symptoms and said he had been avoiding alcohol and illicit substances. It was agreed that a new care coordinator would see X monthly to monitor medication, symptoms, assisting X to undertake more leisure activities, monitor physical wellbeing and liaise

	with his family in monitoring risk and wellbeing. X denied using any substances and said he did not need more support for this.
Beginning of March 2018 .	X's Risperidone was stopped as he had not had psychotic symptoms for over a year. His antidepressant was changed to Venlafaxine. X's Risperidone ceased to be given from this point forward
May 2017	X's care coordinator wrote to the GP to summarise X's care, describing X's `unhealthy lifestyle, his obesity, poor diet and lack of motivation.
July 2017	Notes record that X's anxiety was getting worse. He was showing signs of some weight loss. He reported that he'd taken no cocaine since 2016.
Dec 2017-June 2018	X was visited 9 times over this period.
Early June 2018	CPA meeting – it was agreed that X no longer needed to be managed under CPA. X said he had not had psychotic symptoms since 2016. However, he reported a continuing struggle with low mood which doesn't seem to improve with medication. Medication reviewed and Venlafaxine (XL) increased to 150mg mane (a 28 days prescription for this was given and X continued taking Zopiclone 7.5mg at night if needed.
Mid-July	Next outpatient appointment with Dr E.
Mid-June 2018	X attended for a physical Health Care Check and consented for bloods and all other interventions to be performed. His cholesterol was high, so Dr E wrote to the GP and discussed with X.
Early July 2018	X was seen and reviewed at home by the EIPT staff. He was described as well, no psychotic or other symptoms, no suicidal ideation, no self-harm and no thoughts of harm to others either. Even when low in mood X said that he did not have suicidal thoughts. He said his parents were a major protective factor and they live on the same street. He displayed no signs of agitation or anxiety and maintained good eye contact.
Mid-	X did not keep his appointment with the EIPT.
The next day, September 2018	The team telephoned X who said he was "fine TM, everything absolutely fine". He told me that he did not have transport to bring him and apologised for not calling; he denied suicidal ideation, self-harm and risk of harm to others.
End of September 2018	X was seen and reviewed; he seemed well. Medication: Venlafaxine (XL) increased to 225mg mane and Zopiclone 7.5mg (PRN) prescribed by GP. They discussed `moving on' and step down to PCP (Primary Care Plus) in the New Year. Risk assessment completed.
Mid-November 2018	X was seen and reviewed. No change. Mood still relatively low but otherwise stable. Psychoeducation and medication reviewed. Venlafaxine (XL) increased to BNF maximum recommended dose (375mg mane) plus Zopiclone 7.5mg (PRN). X was invited to participate in the `Moving On' Patient Group but he declined. Living well, exercise and healthy eating discussed and encouraged. X was also encouraged to try doing voluntary work even if it's once or twice per week for a few hours per day, which he said he'd explore. He is still not keen on talking therapies. He said it did not work for him previously.
Later in January	X phoned to say he `had a nasty flu like cold' and could not keep his appointment but would like another.

Mid-February 2019	X did not keep this appointment either. He had missed a couple of appointments with the team because he was taking Diazepam (getting repeat prescriptions) and did not want to be taken off it. X subsequently reported that as he was getting repeat prescriptions from his GP for diazepam (which the HTT, he said, didn't know about) he did not want to see the HTT in case they took him off it. He said he'd had no psychotic symptoms and did not need to see them.
The next day mid-February	EIPT phoned X but there was no reply, so a message was left. They also called X's mother and left a message. A letter was also sent asking him to make contact.
Later in March 2019	X was arrested after being reported by neighbours to be smashing up his house; the caller said he had an air rifle. X was taken to A&E; he was very agitated and unmanageable. He assaulted a police officer and was racially and sexually abusive towards A&E staff.
The day after the above in March 2019	The Mental Health Hospital Liaison Team Practitioner visited A & E just before 9.00 am to assess X but he had already been moved back to the Police station after assaulting a police officer. There, he reportedly took a shower but started to smear faeces on the wall of the cell. Police detained him under Section 136 of the Mental Health Act (MHA).
	Police requested a MHAA but the AMPH declined to attend at the police station, so X was taken to the S. 136 suite at the Campbell Centre where Police records show he arrived at 11.00 am.
	X was assessed at 3.45 pm after it appears to have taken some time to identify a consultant psychiatrist to assist. However, the assessment was completed. No signs of psychosis were detected. X was not deemed detainable under the MHA, did not want a substance misuse referral and was advised to reconnect with the EIPT.
The day after the previous dated entry in March 2019	Police received a call at 12.46 from the ambulance service reporting the attack. X was arrested and taken into custody. A MHAA was requested but declined by the AMPH who reported that as X had been seen the day before he now needed a forensic assessment as a `civil pathway' was not appropriate and he should be put before the Court. Police escalated the matter and several telephone calls took place between the AMPHs, the Senior on-call Manager and the Interim Director for Mental Health.
The day after the previous incident in	Police then took X to the Place of Safety Suite at the Campbell Centre, although the police record states that they were told he would not be seen again there. However, the suite was already occupied. X was therefore taken to the Whiteleaf Centre in Aylesbury.
A further day later in March 2019	X was remanded to prison. However, his behaviour deteriorated over the first week: he began to appear thought-disordered and bizarre in his conversation and behaviour. He was therefore transferred to the clinical assessment unit at the prison where he behaved in an abusive manner to staff, ripped up several mattresses, smeared and ate faeces and drank his own urine. He was started on a dose of anti-psychotic medication (Risperidone 4mg daily) and his relatively high dose of the anti-depressant (Venlafaxine 375mg). He was referred to and then assessed by a Consultant Forensic Psychiatrist from the local Medium Secure Unit who judged X at that time to `more likely than not to be psychotic'.

In mid-April2019.	X was then transferred from prison under Sections 37 and 41[10] of the MHA to a Medium Secure Unit (MSU).
At the end of November 2020	The report author and a DHR panel member met with X at the MSU to discuss the reviews of care and his treatment. X spoke very positively about the care he is receiving at the MSU.

[10] Sections 37 and 41 of the MHA cover respectively the "transfer" of a patient prior to sentencing from prison to a unit specializing in mental health treatment and the imposition of "restriction" to their detention such that the patient may not leave without permission from the Ministry of Justice.

APPENDIX 4: NHSE Level III report

Recommendations for the NHS made after the Rapid Review

1.	CNWL are reviewing their crisis pathway as part of a wider transformation which should provide more capacity to support Thames Valley Police when they are responding to incidents where mental health is a concern.
2	Processes need to be reviewed to ensure that all practitioners ascertain whether a patient in A&E and referred to MHHLT are known to Adult Mental Health Services.
3	There was clearly some communication difficulty between the Mental Health Liaison Team, A&E and the person who made the referral for a mental health assessment, therefore would be benefit in clarifying the referral process between A&E and the Mental Health Hospital Liaison Team to ensure that patients requiring a mental health assessment are seen promptly
4	Multi-agency training would benefit the system in working together, understanding roles and responsibilities and legal literacy with thresholds and boundaries. This needs to take place regularly to take account of change in personnel within all agencies.
5.	There is a need to ensure that the AMHP provides some written information to the Police when a person is discharged from section 136 Mental Health Act. A letter of no detention should be produced and given to the police.
6.	Over the course of the weekend there was a breakdown within the multi-agency partnership, leading to conflict between the Police, the AMHP Service and CNWL. There was a lack of knowledge around escalation policies within CNWL and Milton Keynes Council. It appears that CNWL and AMHP Service failed to understand the police requests for assistance. The Police are not experts in accessing specialist mental health services whilst the mental health services are well-placed to advise and support. On-call information needs to be circulated to all who need to know
7.	CNWL have already started to review forensic pathways as there appears to have been a gap in commissioning. There is now access to the London

	Offender Care Services where there is access to psychiatry. Work to review the forensic pathway continues. Once arrangements have been agreed the pathway needs to be communicated to all agencies and will be included in any awareness training

DHR Appendix 4: Membership of the Joint Review DHR Panel

Gerry Campbell, DHR Chair, Co-Chair of the Coordinating Group
Jane Held, MK Together Partnership Independent Scrutineer & Co-Chair of the Coordinating Group
Linda Chibuzor, Deputy Director of Nursing & Quality, MK CCG
Amanda Derbyshire, Designated Nurse Adult Safeguarding, MK CCG
Amanda Griffiths, Head of LDMH & Autism/GR Local Learning Reviewer
Lesley Halford, Service Director for Mental Health Services in Milton Keynes, CNWL
Anne Richardson, NHSE Reviewer (Psychologist background)
Neelam Sarkaria, DHR Independent Reviewer
Andy Thompson, DCI, Thames Valley Police
Simon Warren, Service Manager MH Services, CNWL/ RCA Author
Louise Morton, Nursing Director, CNWL
Tony Heselton, SCAS Safeguarding Lead
Lisa Johnson, Lead Nurse Adult Safeguarding, MKUHFT
Dr Tayo Kufeji, GP Practice Agency Report Author/Named GP
Helena Peros, Safeguarding Adults, CNWL
Tess Snelgar, TVP Agency Report author
Debbie Yarrow, Compass

<u>MK Together Support</u>
Jo Smart, MK Together Programme Manager
Lesley Mellor, MK Together Partnership Support
Elizabeth Ihejieto, MK Together Project Officer

Appendix 5: Kim's Victim Impact Statement

Thank you for taking the time to read my VIS.

Firstly, I would like to express my concerns about what happens to my brother [Glen] after the criminal trial and the impact this will have on myself and family. Secondly, I would like to address the impact the incident has had.

My concern is that [Glen] will be only treated with medication for his newly-diagnosed mental illness of Schizoaffective disorder, and that the underlying reasons, trauma, triggers, the reason why he takes drugs, etc., leading up to the attack on my parents will not be looked into or, indeed, adequately treated.

Three years ago in June 2016 [Glen] was sectioned for 3 months with a diagnosis of drug induced psychosis. I was present at many meetings with the team looking after [Glen] and asked many times how he would be treated. Prescribed medication was the answer. When I asked if they would be looking at and then treating the reasons why [Glen] felt the need to take self-prescribed medication in the form of street drugs, they said no. I fail to understand how you can stop this happening, if you don't look at the reasons why a person perceives a need to self-medicate?

I watched my brother being detoxed off his drug induced psychosis and visited him weekly for the 3 months he was sectioned - as did my parents. The worry and anxiety that this caused aged my parents. Over the past 3 years [Glen] has become more reclusive, more dependent on prescribed medication and not taking care of his health. That he was not working, shutting himself off in his house, caused my mother and father immense anxiety and concern. I tried many times to offer support and help, ways of trying to get him to motivate himself, but you need continuous support and care to do this. I have watched my parents age dreadfully due to their concern about their son, and the apparent lack of support for any of us in helping him get better to resume what one might call a normal life.

At the time of the attack on (date) [Glen] was still under the care of the mental health team in Milton Keynes. His prescribed medication over the three years was steadily

increased and I find out from paperwork that he did not attend any meetings with the team from at least November 2018.
I have also found out that he did not take his prescribed medication and had been self-medicating again with street drugs. On the Friday at the beginning of the weekend of the incident, going on our past experience with him and his behaviour, my family and I, believe that he was experiencing a drug induced psychosis ve[r]y much like last time.
I have spent the past 4 years in my own professional hea[l]th-care role looking into trauma and how this affects the body, mainly with chronic pain. Much of the work I have done looks at how the brain works with trauma and how the various street drugs affect the chemistry of the brain - by taking the pain away. I believe that my brother has had many traumas in his life, starting in childhood, and then from 2010 onwards when he stopped working and things escalated resulting in the episode in 2016. If he has suffered with this condition for years, his ability to deal with life events will be seriously compromised, especially without proper coping mechanisms and strategies in place. No one has asked myself or family about my brother and what may have caused him to take street drugs.

My Mum and I are concerned that he will be only treated with medication, which of course he can stop taking at any time. Without a serious amount of work, rehabilitation, etc., we are very seriously concerned that there is no kind of certainty to be had that he won't do something similar to either his family or someone else.

Mum is worrying constantly about [Glen]; I have to support her emotionally which is enormously taxing and very difficult. She has not seen him since the attack, and she used to see him every day. Currently with him being at Marlborough house I am able to easily take him things as he needs them and it gives Mum peace of mind that he is nearby. The staff there have been great and they call Mum each week to update her on [Glen] and how he is doing, which is a huge thing for her, and by default me. If a request is at all possible as to where he goes, the family would like him to stay as nearby as possible, purely from a logistical point of view. This will help in the future in getting Mum to see him and re-building that relationship if that is indeed possible. (I live 45 minutes drive away from [location known to the review]).

The impact on a family: - which could have been prevented.

All four members have suffered a life changing event and I have been left dealing with everything.

[Henry] is dead.

[Heidi] is alive, but suffering from the attack both physically, emotionally and mentally. She has lost both her husband and son.

[Glen] has attacked his parents resulting in the death of his father which he has to live with for the rest of his life.

I have lost my father in a terrible way. He was ill prior to the attack and the moment I saw him in hospital the following day on a ventilator, I knew that it would be very unlikely that he would return home, or indeed even regain consciousness.

Dad served in the Korean war and was shot in the head. Every day I saw him I had to tell the new member of staff that if Dad should wake up and be agitated, worried, fearful then you were unlikely to be dealing with this attack, but he would most likely suffering from PTSD and be reliving the last time he was in hospital which was in Korea when he was 19 years old. In fact he did come off the ventilator in the last week and I saw him a couple of times where he just looked so frightened. He was unable to talk to us (maybe due to this tube that they found on postmortem) and communicate his needs which was heartbreaking and so hard to deal with. Thankfully with this information the staff did give him medication to settle him.

Whilst in Coventry we had the added stress of having 2 uniformed police watching him 24 hours a day - they didn't even leave when we visited Dad which caused Mum extreme stress and anxiety. If he were to regain consciousness and see the police standing guard over his bed, but had no recollection of what had happened, how do you explain that your son attacked you? What huge immeasurable pain would this cause him and us the family in having to explain it to him.

The 3 weeks before he died was spent travelling to Coventry for 2 weeks and then MK hospital for the final week. I had police involvement from the beginning and their conduct was deplorable in many instances, to the degree that we have asked for an investigation into their conduct and made a complaint.

Mum was attacked but survived. She is 80 years old. She is requiring a lot of support, physically, mentally and emotionally - and it all falls to me. She and Dad were together over 50 years and never really had a day apart from one another. [Glen] also used to go and see them most days. She has lost both overnight. Due to the nature of the event, information about what was happening to [Glen] was extremely limited, and still is, and it was not until April when he was moved to Marlborough house that we were able to talk with the Matron there and find out how he was doing.

April and May also saw many visits by the police, wanting to talk to Mum and either get information from her or to give information about the various stages that were happening. Non[e] of this was easy for either of us. Watching my Mum either have to relive what happened to her, or her having to sit and listen why another postmortem would have to be performed on her husband and parts of his body taken away with no time frame as to when they may be returned is harrowing.

At every opportunity on recounting what would happen, Mum would hope to get answers. Her son was arrested on the Friday and taken away in an ambulance to MK hospital. She tried to find out what was happening and my husband went over to MK to see [Glen] and the police officers looking after him, so was able to update them Friday evening. On Saturday she spent the whole day trying to find out how her son was, as the last time she experienced this kind of behaviour was when he was having a psychotic attack, to no avail. On the Sunday she has contact with the police and a neighbour takes her to the police station in the morning. When she arrives, her worst case scenario is before her. Clearly her son's behaviour is not right, which she tells the officers on duty and the duty solicitor, but no-one listens. [Glen] is released, but not allowed to be taken home by Mum and her neighbour. They are taken home in a police car, with [Glen] in the cage, all the time Mum is

growing increasingly concerned, worried and anxious, wondering how on earth she is going to cope with her ill son.
How could you put an 80 and 86 year old couple in the position where they had no option but to take their son in to their home, delivered by the police?

Mum was a midwife and as she regularly says, she was responsible and accountable for her actions when she had 2 lives in her hands. No one seems to be prepared to be accountable and responsible for their actions this weekend which saw them both being attacked by their son in their own home with catastrophic results.

This whole event has caused her immeasurable distress and impacted on her blood pressure, sleep patterns, anxiety with me being extremely concerned that she may suffer from a stroke or heart attack.

I see her now twice a week and she also phones me. It is very difficult to listen to your Mum saying how lonely she is, that she can't sleep and wakes at 2.30am, 4am and is up from 6am and has a whole day to face on her own. Before this Mum slept really well and was not a morning person - this change in sleeping pattern is not only making her tired during the day, but is in itself causing her concern and anxiety. Because she is tired she feels that she does not have the energy or mental stamina to face friends and neighbours who ask to have coffee or lunch with her - increasing her feelings of being alone. She is heavily reliant on me, saying each time I communicate with her that she doesn't know what she would do without me, which is a huge responsibility.

I have been unable to work from the date of the attack till the beginning of July when I went back to work for 3-4 hours a week. I am a self-employed osteopath, owning my own osteopathy clinic employing a number of professional[s] and do not see myself increasing the hours that I work till at least next year. I find that working those hours where I see 4 patients very tiring both physically and mentally, something which is new as I loved my job and it never had this impact on me.

I am having to face the fact that I can't work at a job I love and may never go back to what I was doing prior to the attack. My income has been slashed and the lack of my presence in the clinic and also behind the scenes managing the administration side, is also affecting the business.

From March 24th to the death of my Dad on 14th April, I was either going to see them in the hospitals, or taking Mum to see Dad in MK hospital. I live some 45 minutes drive to my parents, and this is 90 minutes to Coventry. I had to be driven by friends and family for the first 2 weeks when they were both in Coventry.

Interspersed with this was having to have various meetings with the police.
After Dad's death, I then had lots of activity from the police and the upset about the coroner's report and subsequent inquest opening.

I was on holiday in May for 2 weeks, which was very much needed. Then I had 10 days to plan the funeral for the end of May.

I now have to take care of Dad's estate and organise probate.

[Glen] has a house. He does not have any funds and from February our Mum had been paying his mortgage. This is a similar situation to last June when he had to sell his other house and he had numerous companies chasing him for outstanding debts - which my parents paid at that time. I had applied initially for court of protection order, which has now been changed to a LPA and I await this - I may have something by the middle of September.

His house needs sorting and clearing which is not an easy task. I have to communicate through solicitors to find out what things [Glen] would like to be put into storage and how he would like his remaining possessions disposed. This is not an easy task on any level - packing up your brother's house whilst he is still alive, a reminder of seeing how he was living and not coping every time I go into the house. My husband and I go one day every weekend to do this process. No one as far as I am aware has asked to see how he was living prior to the attack or taken photos as evidence that he was struggling.

It will need new kitchen, bathroom, flooring, full decoration, garden clearing and landscaping, new front door and the locks replacing on all the doors as the keys to [Glen's] house have been lost by someone in the system - the prison and Marlborough House are both saying they do not have them. This money will have to be borrowed to enable this to be done so that we can realise a good price for the house which will then be sold. All this needs organising and scheduling which falls to me.

Mum constantly worries about [Glen's] house, will it be broken into, grass need cutting, what is happening about the mortgage, will it get repossessed which I have to listen to most times I see her. She is also not sure how she feels if her son at a future time may be able to come back and live just up the road from her, which is also something that concerns me. Selling the house, which [Glen] has agreed to, will allow my brother to be debt free, have funds to use in the future but most importantly will give my Mum peace of mind and therefore reduce the impact on me.

I have yet to see my brother, and have no idea how I am going to react when I see him. I recognise that I still have not processed what he has done to my parents - because how do you do that? He slit my parents throats. I have known for years that he is not a well man, that he is struggling with life and that he needs help, and the [Glen] that I know wouldn't have done that. But he did.

After the criminal case, I shall have to deal with the coroner's inquest, DHR, police complaint, a possible complaint to the mental health care team who have been looking after [Glen] and who made the assessment on the Saturday prior to his release home on the Sunday. There is also the investigation into the tube found in [Henry's] throat by The University Hospitals Coventry and Warwickshire. As you are aware, none of this is done quickly and may take years. Every time I have to attend a meeting, and tell my and the family story to another set of people it affects me hugely. My husband usually accompanies me and we have to take a day. After the meeting I have to go home and rest.

There is also the question of finding out where the keys to [Glen's] house are: neither Woodhill Prison nor Marlborough House appear to have them.

The emotional and me[n]tal stress has been gigantic. My life has been turned upside down. I am of an age where hot flushes and sweats occur - these had been successfully managed until this episode where they flared up again severely which impacted on my sleep and then my health. I get tired very quickly and need to rest most days. My social life has been impacted, as I didn't want to see anyone or indeed have the space or time for the first 3 months after the attack. Only in July have I started to see friends, but find that I can only see them for 2 hours before I get tired and need to leave. I need to strictly monitor what I do each week - seeing Mum, work, [Glen's] house, admin for Dad estate and Mum, meetings with the various agencies etc., so that I can pace myself and make sure that I take care of myself as best I can.

Since the 24th March, life has not been my own.
From this Sunday when I took a call from (Igor), my husband, asking what I was doing and to come straight home.
To be met on my drive by two police officers and asked to go immediately with them, not even go into my house.
To be told that it would be an uncomfortable journey as they would be using the blue lights and sirens to take (Igor) and I to Coventry hospital.
That both my parents were there.
No other information was given until I reached hospital, but one can deduce from the situation that the news could not be good.
On arrival to be ushered into a side room and met by another team of police officers.

From that day, my life is now having to deal with myriads of details and events, with no information given to me until the last minute or I ask.

Each day I wake up wondering what I will have to face and deal with today. Nothing is set in stone and it can turn on a sixpence, be that physically where I have to get myself somewhere or emotional and mentally as the result of a phone call or email. There is no help and the information that is given or asked for usually has short time frames where I need to respond.

For example: [Glen's] last court date was Friday 26th July scheduled for 10.30am. I had been waiting to hear if he was fit to stand trial - which in itself is huge on all levels - and if he would then attend in person. Monday 22nd I hear that he will attend court. Tuesday 23rd afternoon, after seeing Mum in the morning, I get an email asking if I can take [Glen] a suit - so that evening we drive back to MK and do that. My husband and I arrive at 9.30am at the Old Bailey to meet with the police and CPS and are taken to Court 5. I am not allowed to go in and wait outside. [Glen] is late arriving so we are told that it will be 11am. I was able to go onto the empty court room to see what he would see - very distressing. The 11am scheduled case then starts with no-one coming to tell me that [Glen's] case will be heard after this one finishes which could be at any time that morning. Again very little can be told to me as the police made me a witness less than 24 hours after the attack took place and I wasn't even there, so I am left not knowing.

I get a call from Kam, our FLO on Thursday 1st August saying that this VPS is needed, ideally by Monday 4th so that she can type it up and get it signed on Wednesday 7th so it is ready for W/C 12th August. The same day I get an email from her saying that The University Hospitals Coventry and Warwickshire have made contact with her and I have been asked to facilitate a meeting with yourselves - dates either: From Monday 19th to Friday 23rd August or from Tuesday 27th to Friday 30th August.

This is now my life. Whilst I am coping and managing it really well on many levels, it is not alright. None of this is alright. I have been put into a situation not of my choosing, and in my opinion totally avoidable, and with no option to change or get out. This will continue now for the next few years until we have the outcomes of all the various investigations.

I recognise that I have not been able mourn the loss of my father, purely because there is no the space and time to do so. I have no doubt been traumatised, but again till this whole incident is resolved there will not be the time or space for me to do the work fully. My own professional field of work has informed me that trauma and stress has a lasting impact on health and wellbeing - my anxiety about what that will be for me is enormous.

.
There will be both a short and long term impact on both my osteopathic clinic business and my finances.

There are financial impacts in driving to see Mum twice a week, and then paying for all the various legal requirements and the sorting of [Glen's] house.

My marriage has been impacted upon on many levels. [Igor], my husband, has been supporting me each step - but it is impacting on him and adversely affecting his health. For example he dealt with the police at my family home and organised the clean up operation of the attack at the house and saw the full scale mess and destruction of the events that took place. He went to the Coroner's inquest, and the first criminal court date for [Glen]. He was also present in court on 26th July and saw [Glen] for the first time since he had attacked my parents. He is having to process things such as my brother attacking his parents resulting in Dad dying, yet helping me to sort my brother's house so it can be sold. Thankfully he is now having counselling.

Because our weekends are spent helping Mum and sorting [Glen's] house and then days in the week with meetings with the various agencies, our social life has diminished significantly.

We have told our close friends, who have been extremely supportive, about all that we are facing and they understand, but having a conversation as to what we are facing with everyone is not an option.

When talking with friends and acquaintances, how do you say what is happening?
"Yes, my Dad is seriously ill in hospital/passed away"
"My brother attacked them and slit both their throats".
"They were both air lifted to hospital"
"[Glen] was arrested by the police on Friday after smashing his house up and having what we believed, and told the police, a drug induced psychotic episode like he had 3 years ago"

“He was deemed Ok, so the police delivered him home in a caged part of the vehicle to Mum and Dad’s house where he attacked them some 15 minutes later - despite Mum telling them at the police station and in the car that her son’s behaviour was ‘not right’.”

Writing this down brings to stark reality the huge event that has happened to my family, the fall out and the ongoing ramifications. In fact if I look too closely as to what I have had to deal with, and still have to deal with, it can be overwhelming. Overwhelm is where traumatisation occurs, so I do my best to deal with it a day at a time.

Appendix to info regarding trauma, addiction, mental health

Anything by Gabor Mate
Bessel Van der Kolk - The Body Keeps the Score: Brain, Mind, and Body in the healing of Trauma, Traumatic Stress: The effects of overwhelming experience on mind, body and society.
Peter A Levine - Waking the Tiger, In an Unspoken Voice
Sarah Peynton - Your Resonant Self: Guided Meditations and Exercises to Engage Your Brain's Capacity for Healing
Vivian Broughton - Becoming Your True Self, The Heart of Things
Stephan Porges - Polyvagal Theor

Appendix 6: Igor's Victim Impact Statement

23/11/20

Who knew that the expression 'life can change on a sixpence' was so true? Working in electronic manufacturing in the UK brings its challenges and life was hectic and busy enough employing 20 people across two companies trying to stay afloat in this challenging economic climate.

Then [Glen] happened! And in the 610 days that have passed since then and writing this letter I am a different man.

The whole experience which [Kim] has outlined in her statements and spoken about at endless meetings and interviews I have lived and breathed every agonising moment. One step behind, one blood line away from, but I felt every tear.

It is hard to explain how intensely traumatising seeing the one you love be torn apart day after day, month after month and now year after year on so many different levels. I have lived that experience through and beside [Kim] with no end in sight for her (our) pain!

The life we once knew has now gone. In its place is years of uncertainty - what is coming next?! Will the inquest be completed before darling [Glen] gets leave from his soft incarceration? Will the DHR give change that is so desperately needed as the country's mental health declines?

[Heidi's] ever failing health - how will we deal with that? [Kim's] family home, the pain in packing that up when the time comes will be heart-breaking!

Yes, life is a challenge, and we all have these types of things to deal with but when they are shrouded in such a dark veil it is hard to describe how desperately difficult they are to go through and the list is endless.

Remember [Kim] only has me to help deal with this! Her entire family has been taken away from her in the cruelest way imaginable.

But the demands of our life go on bills still need to be paid. [Kim] has had to stop working and while her business is still running the wage she once had now pays to employ someone to run it. So, the responsibility to keep all we have worked hard for and a roof over our heads falls to me. This with the economic challenges we already

confronted added to the new Covid challenge is a huge weight to hold above my head.
Only when you experience life changing events like this are your eyes opened to the complete lack of support and help available for the working man and woman. For example; [Kim] is having a battle with an insurance company to get her income protection to pay out, Legal Aid is limited because we happen to have a few quid saved, the costs to see that those responsible are made to see there failings are increasing into tens of thousands of pounds with not much hope of recovering this hard earnt money. It seems the less you contribute to society the more you get.
Maybe this is more of a rant but the inevitable feeling you are left with skew your rose-tinted view of the world leaving you battered and bruised by the experience.
If you actually care how I have been impacted find me in 5 years' time and ask again because now the days are full of despair, pain & numbness added to a sombre heart while the sands of my life trickle past.

Yours with ever diminishing hope.

[Igor]

Appendix 7: Home Office Quality Assurance Panel Letter

Home Office

Interpersonal Abuse Unit
2 Marsham Street
London
SW1P 4DF

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

Lesley Mellor
MK Together Partnerships
Support Officer
Saxon Gate East Central
Milton Keynes
MK9 3EJ

22nd February 2024

Dear Lesley,

Thank you for resubmitting the report (Henry) for Milton Keynes Community Safety Partnership to the Home Office Quality Assurance (QA) Panel. The report was reassessed in February 2024.

The QA Panel is grateful to the partnership for their review of what is clearly a challenging case. The QA panel praised the detail of the report and acknowledged that there was consistent engagement and involvement with the family throughout the review process. The report was right to share the concerns that Henry and Heidi were never recognised as carers for Glen and highlights the risks that this poses and that more could be done to change this viewpoint going forward. There was a clear and SMART action plan, and the recommendations were set out clearly.

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

The view of the Home Office is that the DHR may now be published.

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

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

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

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

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

Yours sincerely,

Home Office DHR Quality Assurance Panel

Appendix 8: MK Together Safeguarding Partnership's Response to the Home Office Quality Assurance Panel Letter

Following receipt of feedback from the Home Office in February 2024, the MK Together Partnership commenced discussions regarding the publication of the report, ensuring that any key relevant dates were avoided.

Appendix 9: MK Together Safeguarding Partnership's DHR Action Plan

Action Plan to be progressed by MKTSP Assurance Board

	Recommendation	Action	Lead	Timescale	Expected Outcome
	Local				
1	**That all agencies report progress on their internal action plans to the MK Together's Assurance Board**	Assurance Board to assess this action plan and the progress made against recommendations periodically	**MK Together**	**March 2023**	That all recommendations are completed in a timely way unless they are superseded to a higher level by relevant single agency or the multi-agency MK Together partnership activity <u>Update - Closed</u> April 22 - TVP confirmed case has been actioned
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**	Demonstrate how this DHR's recommendations permeate strategy, policies and procedures	**MK Together**	**September 2022**	Strategy, policies and procedures show clear references to this DHR and improve service delivery <u>Update</u> DA Strategic Partnership - The method in which the DASP prioritises and

	Recommendation	Action	Lead	Timescale	Expected Outcome
					directs action and change is fully imbedded. This includes drawing in recommendations and learning from DHRs, SARs and operational activity.
3	**That Thames Valley Police should provide guidance for their frontline Police Officers and supervisory officers regarding what legislative 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**	TVP to provide updated guidance on legislation for use alongside the NDM for front line Police Officers and their managers	**Thames Valley Police (TVP)**	**December 2022**	Improve officer knowledge, understanding and decision-making whilst dealing with mental health incidents <u>Update – Closed</u> TVP have confirmed this has been actioned. 1/9/22 CNWL are participating on actions 3 and 4 in partnership with TVP and developing multi-agency training on the MHA and partner responsibilities.

	Recommendation	Action	Lead	Timescale	Expected Outcome
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 Thames Valley Police's Mental Health Operational Guidance**	TVP to review the success of its mental health training programme TVP to audit the completion of mental health monitoring forms and the decision-making processes, that follows TVP to update its Mental Health Operational Guidance following its audit and review of the above	**TVP**	**March 20Bulletin 23**	Improved awareness, knowledge and understanding of TVP (Milton Keynes) Officers. Improved delivery of services by Police Officers responding to incidents involving people with mental health problems <u>Update - Closed</u> TVP - Mental Health training provision is constantly reviewed and updated. A new package has been developed. Compliance monitoring will be triggered. Audit of pre and post training behaviours isn't feasible, as it is not possible to simply measure what a successful MH contact looks like. Op Guidance has been reviewed and

	Recommendation	Action	Lead	Timescale	Expected Outcome
					clarified. CNWL are participating on actions 3 and 4 in partnership with TVP and developing multi-agency training on the MHA and partner responsibilities.
5	**That the MK Together Partnership, its constituent members and the wider partnership should consider the further enhancement of its whole family[76] practice approach to ensure that the support 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**	The MK Together Partnership to review its policies and operational practices to ensure the Think Family / Whole Family Approach is embedded therein i.e. identify family members affected by the primary client's health condition and/or care/ service need is considered as part of agencies' service delivery That MK Adult Social Care reviews its policy on the conduct of Carer's Assessment	**MK Together**	**December 2023**	That agencies' professionals routinely consider the needs of family members affected by the primary client's health condition and/or care/service requirement. This can include conducting Carer's Assessments, Threat & Risk Assessments <u>Update</u> Tasking Board have signed off current ASC action plan.

[76] 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

	Recommendation	Action	Lead	Timescale	Expected Outcome
					CNWL held the second, very successful, 'think family conference' for staff in September 2022 to promote a family centric approach. In addition, a family involvement audit is completed on each acute inpatient ward once a month.
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**	TVP to consider creating a form similar to the PAC 41G to log all actions, occurrences, care and treatment of an arrestee taken to any place for treatment prior to their arrival at a Police Station TVP to consider how information obtained during 'bed watches' can be disseminated to other partners including health professionals to assist decision making	**TVP**	**September 2022**	That improvements are made in record keeping in a sustained way To provide additional information to assist professional' decision-making <u>Update – Closed</u> CNWL working with TVP to implement record keeping arrangement. Information sharing protocol between agencies has been developed and is at

	Recommendation	Action	Lead	Timescale	Expected Outcome
					comment stage of development.
7	**That MK Together 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**	To set a short programme of multi-agency workshops to review the standards and principles of the Safeguarding working arrangements To develop a plan for enhancing the standards and working arrangement for the Safeguarding Partnership	**MK Together**	**September 2022**	To enhance the effectiveness of the multi-agency team effort working in Safeguarding in Milton Keynes Enhanced effectiveness of the decision-making of the Safeguarding Professionals in MK <u>Update</u> Safeguarding Policies from partner agencies have been collated and this is on the agenda for discussion at February 2023's Tasking Board
8	**That the MK Together's Partnership 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:**	To conduct an up-to-date Strategic Needs Assessment to better understand Domestic Abuse and its drivers To identify how inclusive the partnership is in preventing and	**MK Together**	**December 2022**	An enhanced inclusive approach by local Strategic and Operational Delivery Groups in tackling Domestic Abuse

	Recommendation	Action	Lead	Timescale	Expected Outcome
	d) 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) **e) demonstrating a specific focus on older people as carers and victims/survivors of domestic abuse, and** **f) to inform the delivery of the local Domestic Abuse Strategy and its accompanying action plan**	tackling domestic abuse e.g. does it include non-government organisations (NGOs) and charities in preventing and tackling domestic abuse To review the membership of the Partnership's Strategic and Operational Delivery Groups			Enhanced the effectiveness and qualitative outcomes of the Partnership for the benefit of local people. <u>Update - Closed</u> Strategic Partnership Board Chair shared the cabinet report into current activity, progress and outcomes with the Assurance Board, who agreed that the structure is effective.
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**	Review of on-call arrangements for psychiatrists and other key staff providing out of hour mental health crisis response	**CNWL**	**September 2022**	A further enhanced service delivery to patient and multi-agency partners <u>Update</u> Out of hours policies collated and on agenda to be discussed by Tasking

	Recommendation	Action	Lead	Timescale	Expected Outcome
					Board in February 2023.
10	**That the MK Together Partnership tests its partnership protocol arrangements for their effectiveness outside of recognised office hours including weekends**	Reality check the out-of-hours partnership arrangements on a periodic basis to ensure the service is meeting expect standards	**MK Together**	**July 2022**	Further enhance the partnership and the effectiveness of its service delivery to local people and local partnership organisations <u>Update - Closed</u> CNWL have submitted a copy of the on-call policy which includes the dedicated phone numbers that can be utilised for escalation
11	**That the MK Together Partnership reviews the effectiveness of its partnership protocol within 12 months following implementation**	Multi-agency Review of the new partnership protocol arrangements	**MK Together**	**March 2023**	Enhanced partnership and the effectiveness of its service delivery to local people, local partnership organisations and strengthen the signatories working relationships <u>Update</u>

	Recommendation	Action	Lead	Timescale	Expected Outcome
					Taken to DASP board in August 2022, presentation and discussion at Novembers meeting.
12	**That the MK Together 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**	To set a short programme of multi-agency workshops to review the standards and principles of the Safeguarding working arrangements in the context of the audit To promulgate the progress of the audit's action plan across the partnership	**MK Together**	**December 2022**	Improved effectiveness of the multi-agency team effort working in Safeguarding in Milton Keynes Enhanced effectiveness of the decision-making of the Safeguarding Professionals in MK <u>Update</u> Merged with Rec 7
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**	The Clinical Commissioning Group provides guidance as part of its commissioning arrangements to all Providers to supply the police with a document outlining treatment received including medication provided	**CCG**	**September 2022**	Supports the Police Healthcare Provider's medical assessment of and response to detainees Contributes to the prevention of medical

	Recommendation	Action	Lead	Timescale	Expected Outcome
	their statutory duties in the care of detainees				emergencies in Police detention <u>Update - Closed</u> TVP supervisors advised that each S136 from custody needs to be risk assessed prior to release – if we require the person back immediately on release clear direction must be provided on handover and a point of contact provided. MKUH will share a discharge summary template with TVP which will highlight information of physical health. MKCC, L&D and TVP have regular meetings to discuss ongoing challenges. Have set up a regular meeting between L&D team and TVP so they can have an open forum to discuss any ongoing

	Recommendation	Action	Lead	Timescale	Expected Outcome
					challenges that might arise in Police custody. MKCC also have an on-call system in place which the Out of Hours team have access to, should issues require escalating. discuss any ongoing challenges that might arise in Police custody.
14 (a)	**That Thames Valley Police:** **(iii) 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.** **(iv) further develops its approach to the provision of Appropriate Adults particularly for vulnerable adult detainees.**	Review arrangements for the provision of Appropriate Adult Services in TVP detention facilities Review the provision of support information available for / provided to vulnerable detainees and their appropriate adults (if family members) at the time of the detainee's release from custody	**TVP**	**September 2022**	Improved knowledge and awareness of support services Improved risk management plans for post release of vulnerable detainees Reduce the risks of harm to/from the vulnerable detainee

	Recommendation	Action	Lead	Timescale	Expected Outcome
14(b)	**That the MK Together 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**	Each Partnership agency to review its processes and procedures for the provision of support information / advice to service user's family member, guardian, carer etc	**MK Together**	**December 2022**	Improved knowledge and awareness of support services Improved risk management plans for vulnerable service users Reduce the risks of harm to/from the vulnerable service users <u>Update - Closed</u> 1/9/22 Information on detention under the MHA is provided for family as described in the MHA code of practice. The AMHP is responsible for contacting family at the time of an MHA assessment which includes the gathering of information.
15	**That the MK Together Partnership leads a multi-agency event and other work, which captures the learning**	Conduct at least one multi-agency event to promulgate the	**MK Together**	**Nov 2022**	Enhanced local professionals'

	Recommendation	Action	Lead	Timescale	Expected Outcome
	from the actions in the aftermath of the attack on 24 March 2019 and following Henry's death on 14 April 2019	learning from the Domestic Homicide Review			knowledge, awareness and understanding Enhanced service delivery by local professionals <u>Update</u> Executive Summary to be distributed to all relevant agencies within MK to use in team meetings and 1-1s in order to disseminate learning.
	National				
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**	Review the Overview Report and considers dissemination to the National Police Chiefs' Council Leads	**Home Office**	**June 2022**	Improvements made in the service areas identified for the benefit of the public Enhanced capability of police officers in operational practice in the identified areas

	Recommendation	Action	Lead	Timescale	Expected Outcome
	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				
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**	Review of the Statutory Guidance for the inclusion that DHR Chairs / Overview Report Authors consider the wider impact of homicide e.g. trauma and secondary trauma	**Home Office**	**December 2022**	Best practice in supporting families and professionals following fatal domestic Abuse Best practice is identified in how professionals provide a trauma informed approach / response to family members and professionals after a DA homicide