Safer Sandwell Partnership

Domestic Homicide Review
Executive Summary Report

Jeera and Amrinder
(who died in early 2020)

Author: Simon Hill

Please note that this document contains descriptions of violence which people may find distressing.

The Safer Sandwell Partnership, the Independent Domestic Homicide Review (DHR) Chair, panel members and participating agencies join in expressing our sincere condolences to the families, friends and colleagues of Jeera and Amrinder for their loss.

The Review Process

1. This summary outlines the process undertaken by the Safer Sandwell Partnership Domestic Homicide Review panel in reviewing the homicides of Jeera and Amrinder who were residents in their area. Jeera and Amrinder were stabbed to death by Jeera's son Gurnam. The Home Office Guidance advises that confidentiality of family members identities should be assured by anonymisation. The pseudonyms used in the report were chosen by Deepika.

   The victims were:

   Jeera was 52 at the time of the homicides and was mother to the perpetrator and to Deepika who was of Asian ethnicity and a follower of Sikhism.

   Amrinder was 54 at the time of the homicides, was stepfather to Deepika and Gurnam and was of Asian ethnicity and a follower of Sikhism.

   The perpetrator was:

   Gurnam who was 25 at the time of the homicides, was of Asian ethnicity, and was a follower of Sikhism.

   Family members:

   Deepika was the daughter of Jeera and Jaswinder, and sibling of Gurnam and was 22 at the time of the homicide.

   Jaswinder was Jeera's ex-husband and Gurnam and Deepika's father.

2. In early 2020 notification was sent by the West Midlands Police Public Protection Unit to the Domestic Abuse Incidents Review Coordinator within Sandwell's Domestic Abuse Team, advising that the circumstances of this case may fit the definition of a Domestic Homicide Review as defined in the Domestic Violence, Crimes and Victims Act 2004.
3. Following notification of this incident, the Domestic Abuse Team collated a range of information from partners to establish the contact they had had with the victims, the perpetrator and family members.
4. The information from partner agencies was shared with the DHR Standing Panel and Chair of the Safer Sandwell Partnership who, on 16.03.2020, decided that the criteria for holding a Domestic Homicide Review under Section 9 (3) of the Domestic Violence, Crime and Victims Act (2004) was clearly met and directed that such a review be carried out into the circumstances surrounding this case. The Chair of the Safer Sandwell Partnership Board confirmed this on 16.03.2020.
5. Criminal proceedings were completed in the summer of 2020 and the perpetrator was sentenced to a minimum of 36 years for murder.

Contributors

- Clinical Commissioning Group (Sandwell & West Birmingham & Northamptonshire) - now known as NHS Integrated Care Boards
- Black Country Healthcare NHS Foundation Trust - formerly Black Country Partnership NHS Foundation Trust
- Sandwell & West Birmingham Hospitals NHS Trust
- The Dudley Group NHS Foundation Trust
- Child and Adolescent Mental Health Services CAMHS Northants
- Sandwell MBC Education
- Birmingham CC Education
- Sandwell Children's Trust (including Sandwell Youth Offending Service)
- National Probation Service (Black Country cluster)
- West Midlands Police
- Children First Northamptonshire (CFN)

(Chair's Note: The DHR approached the Child and Family Court Advisory & Support Service (CAFCASS) to request they contributed to the Review; however, due to delay by Sandwell MBC Legal Services in an application to the Family Court, the DHR obtained relevant information from the family's own records.)

Review Panel Members

Organisation	Role
N/A	Independent Chair and Overview Author (Simon Hill)
Sandwell & West Birmingham Clinical Commissioning Group Now NHS Black Country ICB	Designated Nurse for Safeguarding Adults
Sandwell & West Birmingham Hospital NHS Trust	Named Nurse for Safeguarding Children
Black Country Healthcare Foundation NHS Trust[1]	Interim Safeguarding Consultant
National Probation Service	Deputy Head of Probation - Black Country
Black Country Women's Aid	Chief Executive Officer
Sandwell Children's Trust	Service Manager – Quality Assurance and Safeguarding Unit
Youth Offending Services Sandwell Children's Trust	Deputy Service Manager - Youth Offending Team

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[1] **Formerly Black Country Partnership NHS Foundation Trust**

Education, Sandwell MBC	MASH Education Officer - Attendance & Prosecution
Neighbourhoods, Sandwell MBC	Lead Community Safety Co-ordinator
West Midlands Police	Detective Inspector, Public Protection Unit
Sandwell MBC	Domestic Abuse Team Manager
Sandwell MBC	Domestic Abuse Incidents Review Coordinator
Sandwell MBC	Core Business Support Officer

The Overview Report Author

1. The DHR Chair / Overview author, Simon Hill, is a retired West Midlands Police officer, who served on the Public Protection Unit, investigating both child and adult protection cases. For 5 years he was responsible for the Review Team contributing IMRs to SARs, Safeguarding Child Reviews and Domestic Homicide Reviews.
2. He has conducted numerous DHRs and SARs around the West Midlands region in the last seven years. He regularly presents learning from SARs and DHRs at events held by Safeguarding Partnerships as well as facilitating multi-disciplinary workshops. For the last four years he has provided Level III Adult and Child Safeguarding training for CCGs and Hospital and Mental Health Trusts.
3. He was not involved with any of the events which are the subject of the review and was no longer serving as a police officer during the timeframe under review.

Terms of Reference

1. All agencies were asked to review their involvement with the family during the period between 2002 when the family moved to Sandwell until Jeera and Amrinder's death in early 2020.
2. Initial scoping suggests that from around 2004 to 2012, child to parent[2] abuse (CPA), also called child and adolescent to parent violence and abuse (CAPVA), played a significant part in the family history. It appears that the victim, Jeera, and the perpetrator's younger sibling, Deepika, as well as the perpetrator's father, Jaswinder, were all possibly victims of what would be recognised now as a form of domestic abuse at the hands of Gurnam.
3. The Chair and panel recognise that understanding of CPA has developed significantly since the events captured in the initial scoping.
4. The DHR will seek to identify the pathways to support for families experiencing CPA that currently exist and identify relevant learning for service providers in 2021. We will consider how effectively agencies manage both child and adult safeguarding in the context of CPA.

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[2] **There is no definition of CPA but this definition is helpful from Holt A. (2015) Working with adolescent violence and abuse towards parents: "*a pattern of behaviour, instigated by a child or young person, which involves using verbal, financial, physical and/or emotional means to practice power and exert control over a parent…The power that is practiced is, to some extent, intentional, and the control that is exerted over a parent is achieved through fear, such that a parent unhealthily adapts his/her own behaviour to accommodate the child.*"**

5. (There is a distinction to be drawn between child/adolescent violence and abuse in part because, since 2013, 16 and 17-year-olds can be either victims or perpetrators of domestic abuse under the Home Office definition of domestic abuse and adolescent to parent abuse was recognised as a domestic abuse issue.)
6. Child/adolescent parental abuse clearly can continue after the abuser is 18. In this case, the perpetrator turned 18 years of age in 2012. Engagements and incidents thereafter, whilst no longer CPA, should be considered, to identify if safeguarding responses to the risk of domestic abuse were appropriate and informed by the known antecedent history, which included domestic abuse-related cautions and convictions whilst an adolescent and a young adult.

All individual management reviews should address the following specific issues identified in this particular case:

1. What knowledge or information did your agency have that indicated Jeera and Amrinder might be at risk of abuse and Gurnam a perpetrator of domestic abuse?
    - How did your agency respond to this information to protect them?
    - Was this information shared?
    - If so, with which agencies or professionals?
2. Did your agency have policies and procedures for Domestic Abuse, Stalking and Harassment (DASH) risk assessment and risk management for domestic violence and abuse victims or perpetrators (including updated assessment tools)?
    - Were those assessments used correctly in this case?
    - Does your agency have identified pathways to support perpetrators, as well as victims of domestic abuse?
3. Should your agency be using 'routine enquiry', in line with current NICE guidance (or enquiry where health indicators that could indicate domestic abuse are present), to establish if a client is a victim of domestic abuse? Did any opportunities arise in your agency's engagements with the victims, that meant they should have been asked such questions? Were such conversations recorded in client notes?
4. In assessing your agency's responses to domestic abuse risk in this case, what difference did it make (if any) that the case involved a son posing a risk to parents and a step-parent, rather than an intimate or former intimate partner?
5. Were professionals sensitive to the ethnic, cultural, linguistic and religious identities of the victims, the perpetrator and their families? Was consideration for vulnerability and disability necessary? Were any of the other protected characteristics relevant in this case?
6. To what extent in your agency's involvement with the family is there evidence that professionals adopted a holistic approach to identify domestic abuse risk and any child or adult safeguarding issues? How did your agency assess whether Jeera and Amrinder were able to articulate what was happening in their lives (on those occasions when either party accessed services)?
7. Identify any occasion where your agency was approached by either of the victims, or other family members, seeking either to:
    - share information concerning risk from the perpetrator,
    - or to obtain support for the perpetrator.

    Were responses appropriate?

What, if anything, prevented your agency sharing information or taking action?

Were they signposted to other agencies or organisations?

8. There is evidence from scoping that at various points from adolescence into adulthood, the perpetrator was using alcohol and cocaine. (Sandwell DHR 9 acknowledged the risk from cocaethylene; including psychosis.)

   Jeera and Deepika are believed to have shared their concerns about the signs of psychosis exhibited by the perpetrator and his use of alcohol and drugs.

   - Was your agency aware of these co-morbidities, and what support and safeguarding advice was given to the perpetrator or family?
   - Could the response have been improved?

9. Identify any lessons learnt and implemented during the review process.

   - Are there lessons to be learnt from this case relating to the way in which this agency works to safeguard victims and promote their welfare, or the way it identifies, assesses and manages the risks posed by perpetrators?
   - Where could practice be improved?
   - Are there implications for ways of working, training, management and supervision, working in partnership with other agencies and resources?

10. How has your agency implemented the West Midlands Domestic Violence Standards (link)?

The following agencies should, in addition, answer questions 11 to 16 below that relate to what appears to be an emerging theme of this DHR, child to parent violence and abuse:

- CCG (Sandwell & West Birmingham & Northamptonshire)
- Black Country Healthcare NHS Foundation Trust - formerly Black Country Partnership NHS Foundation Trust
- Child and Adolescent Mental Health Services (CAMHS) Northants
- Sandwell MBC Education
- Birmingham CC Education
- Sandwell Children's Trust (including Sandwell Youth Offending Service)
- National Probation Service (Black Country cluster)
- West Midlands Police
- Children First Northamptonshire (CFN)

11. Identify whether CPA was recognised by your agency in policy, procedures, data recording or operational practice, during engagements with the perpetrator or members of the family and describe the impact this had.

12. Regardless of whether CPA was formally identified, consider any indications of professionals assigning responsibility for the behaviours to the child or the parents, rather than considering they were vulnerable individuals in their own right. Did professionals identify what they believed were causes or factors impacting upon the child's behaviours and, if so, were these recorded and acted upon?

13. Although CPA may not have been recognised, how effectively did agencies work together to support Gurnam and his family? What were the challenges encountered and how were they addressed?

14. Did agencies recognise that Deepika was a victim/at risk of abuse from her sibling? Were any child safeguarding procedures followed in relation to Deepika?

15. Describe whether your agency now has clear policy and procedure or guidance relating to CPA and in what ways (if any) would your agency expect colleagues to respond differently to the same CPA concerns, were they reported today?

16. What learning can you identify for your agency from your review of this case, in relation to CPA?

Question 17 is to be answered by:

CCG (Sandwell & West Birmingham & Northamptonshire)

Black Country Healthcare NHS Foundation Trust - formerly Black Country Partnership NHS Foundation Trust

Sandwell & West Birmingham Hospitals NHS Trust

17. In identifying health provision and pathways to support that may have been offered or provided to Gurnam, consider any:

    - Evidence of health inequalities in what was available
    - Service provision addressing the inequalities

that are known to be experienced by ethnic minority groups in Sandwell.

Question 18 is for Sandwell Children's Trust

18. In 2013, the National Probation Service apparently attempted to access antecedent child protection information in relation to Gurnam, a former Looked After Child, who had been convicted of a domestic abuse-related offence. The information was not shared, apparently because Gurnam was no longer a child.

    - Was a refusal to share information in line with policy in these circumstances? (Does this remain the case in 2020?)
    - How could an agency working with an adult find out from Sandwell Children's Trust about relevant child protection history that may have a bearing upon adult safeguarding?

Question 19 is for Children First Northamptonshire (CFN)

19. Gurnam had been a Looked after Child in Sandwell from March 2010 to August 2010 and had spent some months in residential care.

    - To what extent was the support offered by CFN to Gurnam under a CIN plan, informed by a clear understanding of the period Gurnam spent as a LAC?
    - Identify what CFN would consider to be 'best practice' were the same concerns and history encountered in a child protection case in 2020.

Summary Chronology

1. Jeera married Jaswinder in 1993 and moved to the UK. They had two children, Gurnam and Deepika. (Jaswinder had been married before, but that marriage ended when his first wife left, alleging abuse.)

2. The family lived in Northamptonshire. Jeera apparently experienced a significant amount of physical and emotional domestic abuse at the hands of her husband which was often witnessed by Gurnam and Deepika. Jeera had described how Jaswinder regularly threatened to kill her (Jeera). Living as the family

did with the extended family, Jeera experienced bullying by her mother-in-law and sister-in-law, towards whom she was expected to be subservient. They allegedly were complicit and encouraged the domestic abuse by Jaswinder.

3. Jeera escaped from Jaswinder in August 2002 and moved with her children, first to relatives and then to a refuge in the West Midlands. Gurnam was 8 and Deepika was 5 years old. Jeera was then involved in a protracted and acrimonious custody battle with Jaswinder during 2003 and 2004. Probably because of her isolation, language difficulties and cultural norms, Jeera never reported the Northampton domestic abuse incidents to Police. This enabled Jaswinder to deny all allegations made against him or his family during the custody dispute. The children's guardian reports and a subsequent psychiatric assessment of the children in February 2004 recognised their presentation was consistent with having lived with and experienced the impact of being both victims of, and witnessing, domestic abuse upon Jeera.

4. Gurnam was first referred to Child and Adolescent Mental Health Services (CAMHS) in October 2003 by his primary school. He was already at risk of exclusion due to '*extreme behaviour issues'.* The referral letter provided vivid descriptions of Gurnam's concerning behaviour; physically aggressive behaviour towards female staff and his mother, typical behaviour patterns of anger, inappropriate talk about and interest in death, hurting people or animals and playing games mimicking shooting and fighting.

5. Due to various factors described in the Overview, Gurnam was not seen by CAMHS until he was ten years old, in March 2005. Gurnam's mother, Jeera, spoke poor English, but was rarely supported by an interpreter and therefore struggled to explain her perception of her son's problems. (Some of the psychiatrists the family worked with spoke some Punjabi, but not as a first language.) The CAMHS sessions concentrated on Jeera's apparent inability to control her son or set boundaries and there was little or no evidence of one-to-one work with Gurnam. Similarly, no active consideration of child to parent abuse (CPA) from a safeguarding perspective was given in relation to Jeera or her daughter Deepika, who were both at risk from Gurnam.

6. In September 2007, at thirteen years old, Gurnam was first arrested for an assault upon his mother causing injuries. Jeera, whilst reporting assaults by her son, would never support prosecution, apparently hoping that with time he would 'grow out' of his abusive behaviours. He was referred to Children's Services, however there was no active involvement with the family. Gurnam was re-referred to CAMHS by his GP. Gurnam had started to exhibit self-harming behaviours.

7. Gurnam spoke to psychologists openly about his fascination with weapons and did not show any remorse or empathy for his mother or sister, or peers at school he had assaulted. It was recognised that the level of violence and intent shown required a mental health assessment. He was assessed as not showing evidence of psychosis and CAMHS continued to concentrate upon 'behavioural change' and Jeera's boundary setting. It is of note that again almost no one-to-one work was carried out with Gurnam to achieve changes in behaviour or understand the root causes.

8. In 2010, at fifteen years old, Gurnam's physical abuse of his mother and sibling continued and he was now abusing alcohol and cocaine. He was physically far stronger than his mother who frequently had to resort to locking herself and her daughter into rooms, taking all sharp implements into the room with them for safety. Gurnam was again arrested for assault of his mother, but he was not charged or cautioned. A joint police enquiry in the West Midlands and Northampton occurred in February 2010, after a psychologist warned of worrying and serious threats by Gurnam to harm his father.

9. A third period of involvement with CAMHS occurred, where a psychologist recognised signs of psychosis in Gurnam and referred him for a psychiatric assessment. Children's services recognised that Jeera and

particularly Deepika were at risk and after joint work between the social worker and psychiatrists, Jeera agreed to Gurnam becoming a Looked After Child (LAC). He was accommodated for a period of 11 weeks during which time he turned 16 years. In January 2010, Gurnam moved into a Children's Home. No therapeutic work was carried out with Gurnam, there were no attempts to prevent his association with friends who used alcohol and drugs and the period simply represented a short respite for Jeera and Gurnam. At sixteen years old, in July 2010, Gurman was discharged from care with his mother's consent and he refused further Children's Services support.

10. In early August 2010, Gurnam was involved in an assault at his Gurdwara, when two Sikh elders sustained injuries inflicted by Gurnam, but would not press charges. Jeera concluded that Jaswinder, Gurnam's father, could perhaps control his son and so agreed to his moving to Northampton. Gurnam's Children's Services case was closed in mid-August 2010.

11. In late 2010 and in early 2011 Gurnam's paternal family reported to Police domestic abuse incidents and then assaults by Gurnam upon his father and aunt. Identified as a Child in Need (section 17 Children's Act), Northampton Children's Services involvement was largely ineffective. A referral to CAMHS was not accepted by the service. Gurnam remained aggressive, violent, and obsessed with weapons.

12. In January 2013, at eighteen years old, Gurnam was charged with offences of harassment against his father and aunt and sentenced to a 12-month suspended sentence requiring 12 months' supervision and 200 hours of unpaid work. He ultimately returned to the West Midlands where he was supervised by Probation.

13. Gurnam lived with friends and in hostel accommodation but in the autumn of 2016, Gurnam moved back in with his mother. His sister opposed this move but had left for university that month. In early 2017, Gurnam was arrested for, but not charged with, an assault upon his mother. Jeera remained at almost constant threat from Gurnam. However, in 2017 Jeera met Amrinder, her second husband, and in 2018 she moved into his home. Gurnam remained in the family home.

14. In 2018, Gurnam was presenting at his GP with symptoms of anxiety and depression as well as in A&E with inflicted injuries, apparently from fights. He admitted to consuming large quantities of alcohol and cocaine but was not directed to substance misuse services.

15. In September 2019, Jeera and Deepika sought a mental health assessment for Gurnam, first through his GP and then by taking him to an A&E department. They described what they felt was evidence of his psychosis and outlined the threats he had made to kill them, which they felt were real. Triaged at hospital, and refusing a voluntary mental health assessment, Gurnam was not considered to be in crisis and could not therefore be compelled to be assessed and possibly detained for treatment under the Mental Health Act.

16. Jeera continued to try and support Gurnam and, in early 2020, she and Amrinder her husband encouraged him to move in with them. Very soon after, Gurnam stabbed both his mother and Amrinder to death in their home.

Key Issues identified by the review

- Adverse Childhood Experiences (ACEs)
- Child to Parent Abuse (CPA)
- Intrafamilial domestic abuse
- Supporting families to access mental health services

1. Gurnam's exposure to domestic violence and abuse and ACEs would apparently cause emotional and psychological trauma that may have led him to resort in childhood to coercive and controlling and violent behaviours against his mother and sister, to impose his will. Into adolescence, these behaviours persisted, fully recognised but largely unchallenged and unaddressed.
2. As an adult, Gurnam was domestically abusive towards members of the extended family. The anger he had carried with him since childhood, aimed at his abusive father, meant that his father and close relatives, in turn, became victims of domestic abuse.
3. The DHR recognised that the key events in this case occurred during a period of evolution in our understanding of the nature and extent of child to parent abuse (CPA) and the devastating impact it can have across generations.
4. The DHR recognised significant victim blaming by professionals in their response to CPA. Jeera had experienced injury, humiliation, degradation and coercion and control in her first marriage. Far from being 'weak' (a term used repeatedly to describe her parenting of Gurnam) she had shown incredible strength, to escape her abuser and free her children from the experience of abuse. She lost a home, financial security, and family support.
5. Professionals from several services; GPs and CAMHS, Children's Services, concentrated first on '*poor or weak parenting'*, then on Gurnam's mental health, then tried removal of Gurnam to reduce risk by arrest or voluntary placement in care. Yet Gurnam grew into adulthood still driven by the same harmful beliefs and impulses. Far from agencies working with the whole family to bring it together, it remained fractured and, with hindsight, at fatal risk of harm.
6. The physical and emotional abuse that Gurnam used against his immediate and extended family was apparently not recognised as domestic abuse and demonstrated a weakness in dealing with intrafamilial domestic abuse.

Lessons Learned

The Impact of adverse childhood experiences (ACEs) on adult outcomes

Learning point: Professionals should be aware of the evidence of the harmful impact of domestic abuse on babies 'in utero' and infants, as well as older children.

Learning point: In assessing the needs of a child, practitioners should consider that a child may mask their distress, to 'shield' other family members from its impact.

Child to Parent Abuse (CPA)

Learning point: Professionals should be aware that CPA can start early (8 to 9 years) and become an entrenched problem.

Learning point: Responses to CPA need to be commenced early to reduce the risk of escalation.

Learning point: Children's experience of domestic abuse is a possible predictor for their later use of abuse within the family.

Learning point: In relation to CPA, agencies should be wary of closing a case based on non-engagement.

Learning point: In relation to CPA, professionals should avoid blaming language and recognise that there is a difference between shaming an adult or child and accountability for their actions.

Intrafamilial Domestic Abuse and domestic homicides

Learning point: Where an adult parent is a victim of domestic abuse by their adult child, Police should be professionally curious and consider the possibility of CPA and seek details of history to identify the early onset of abusive behaviours in the offender.

Supporting families to access Mental Health Services

Learning point: It is important that mental health professionals and GPs are reminded of the link between anosognosia and schizophrenia when identifying a patient's apparent lack of insight into their mental health condition.

Learning point: GPs and other professionals should be aware of the right under section 13(4) of the Mental Health Act (1983) for the nearest relative to request that an Approved Mental Health Professional (AMHP) assess their relative.

Conclusions

1. The DHR was enhanced by the perceptive and constructive observations of Deepika, who spent most of her childhood and early adult life supporting her mother, Jeera, to find appropriate responses to her brother's behaviours, as her mother tried her best to keep them all safe and achieve positive change. Tragically, the family were seeking support from professionals at a time where there was a lack of awareness of ACEs, and where practice was rarely fully trauma-informed.

2. Although Child to Parent Abuse was beginning to be recognised and described, understanding of it was not widespread, even across agencies that would be expected to deal with its affects. Consequently, there was limited evidence of the 'Whole Family' approach that should be taken in 2021. The DHR's recommendations aim to ensure that Sandwell adopts best practice in relation to this complex area.

3. It is not surprising, though, given Gurnam's behaviours, that Jeera and Deepika were persuaded from an early point that the root cause was Gurnam's undiagnosed mental health problem. That mental health professionals did not explore with them in a methodical way, their assessment of Gurnam as a child, or the impact of ACEs or link behaviours to trauma, meant that the family persisted into Gurnam's adulthood in seeing mental health support as the only viable solution to Gurnam's issues. The learning

from this DHR would suggest that Early Help in its broadest sense, including working with the family to understand their shared trauma, may have prevented the steady and relentless collapse of the family and the deterioration in Gurnam's mental health.

4. What is clear from this sad case is that probably only early interventions involving the whole family, supported by all relevant agencies, can prevent CPA becoming entrenched to the extent that a perpetrator poses a threat of interpersonal violence into adulthood.
5. The clear, explicit threats of violence so often made by Gurnam to his mother and sister never assumed the prominence that, with hindsight, they should have. In part, this was because Jeera believed until the end her son could change, and therefore was reluctant to report these chilling threats to the Police.
6. That Gurnam was never formally assessed by mental health professionals in adulthood and was not referred to mental health services by his GP or ED staff, because he was unwilling to engage, meant the family's concerns went unaddressed. They felt in the months before the homicide that he was exhibiting elements of psychosis and was a danger to them and others. The unsuccessful request to obtain such an assessment in ED failed because of a combination of an apparent lack of 'florid' mental health symptoms, an ill-conceived plan to get Gurnam to the hospital and a triage process undertaken by a nurse with insufficient training in mental health and a lack of experience.
7. The lack of awareness of pathways to Mental Health support meant the family were given only limited guidance on the rights of a nearest relative to seek an AMHP assessment. The DHR will never know what the outcome of such an assessment in the last months of Jeera and Amrinder's life would have concluded. It is possible that he would have been identified as suffering a mental health crisis requiring emergency assessment and hospitalisation.

Recommendations

The Domestic Homicide Review recommends that:

1/That the Sandwell Children's Safeguarding Partnership include a new annexe in the Sandwell Threshold Guidance document, that assists all professionals to understand, identify and assess the Early Help needs of the whole family in relation to Child to Parent Abuse (CPA) and promotes age-appropriate responses to child safeguarding.

2/That the CPA Guidance currently being developed in Sandwell builds upon the current Home Office Guidance, by describing how Sandwell agencies should respond to CPA in a multi-disciplinary and holistic way, recognising both child and adult safeguarding, as well as the importance of a 'Whole Family' approach to assessing that family's needs and wishes concerning CPA. The guidance should recognise that appropriate responses would take into full account the vulnerabilities of both the child and the adult and should be regularly reviewed where risks remain, as a child moves into adolescence or becomes a young adult.

3/That a multi-agency, case study-based training package on CPA be created that could be delivered to frontline professionals, having as its objectives to increase understanding of CPA and awareness of best practice in line with the new Sandwell Guidance on CPA.

4/ That the Black Country Healthcare NHS Foundation Trust (BCHFT) should review existing pathways into the Trust's mental health support and update them where necessary, and promote those pathways with the Black Country & West Birmingham Clinical Commissioning Groups and all Hospital Trusts referring into BCHFT:

- **The pathways should facilitate professionals in Primary Care teams and Hospital Trusts with Emergency Departments, to make appropriate and timely referrals into the Trust Mental Health services.**
- **It should enable those same professionals to correctly advise families when and if they can access mental health support for a family member who has capacity, where that person is either compliant or non-compliant.**
- **It should identify how professionals and families (including 'nearest relatives'), should access emergency assessment and potentially treatment, where they believe that family member to have a mental disorder of such a nature and degree that they are at risk of harm to themselves or others.**
- **The pathways should also clearly identify to the public when and if self-referral into Trust services, or referral into mental health services on behalf of a family members, are appropriate.**

5/The Sandwell and West Birmingham Clinical Commissioning Group, Sandwell and West Birmingham Hospitals Trust and University Hospitals Birmingham NHS Foundation Trust should ensure that their practitioners are aware of the scope and application of section 13(4) of the Mental Health Act and are aware and can advise in relation to when it may be appropriate for the 'nearest relative' seek an assessment from a Local Authority AMHP. The advice should complement current guidance to primary and secondary care in relation to seeking access to mental health support for patients.

6/ Sandwell Metropolitan Borough Council Adult Social Care and Birmingham City Council Adult Social Care should ensure and provide assurances that pathways and online guidance to section 13(4) MHA 'nearest relative' assessments requests are clear and accurate, properly publicised and understood by call handlers receiving requests for such support as well as those managing and providing this service within Adult Social Care.