DOMESTIC HOMICIDE REVIEW

EXECUTIVE SUMMARY

Report into the Death of a Woman in April 2018

Report produced for East Sussex Safer Communities Partnership by

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Associate of Standing Together Against Domestic Violence

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Contents

Executive Summary

1. Background

1.1 This review concerns the circumstances leading to the homicide of a fifty-one-year-old woman by her twenty-two-year-old son. In order to protect the identities of individuals affected by this review, the report has been anonymised and the term 'victim' used instead of a pseudonym, on the request of the bereaved family.

1.2 After returning from the United States where his musical career was cut short due to arthritis at the age of 19 years, the perpetrator returned to live with his mother and quickly displayed erratic behaviour. A thorough and prolonged mental health assessment was undertaken but his episodic mental illness was found to be a result of his problematic use of alcohol and drugs.

1.3 Over the next two years, he went on to target his mother through burglary, theft and aggressive demands for money, as well as commit a series of acquisitive crimes and make financial demands of the extended family. As a result, he was arrested and taken to court several times but evaded a prison sentence on the basis of community orders and drug rehabilitation orders, which he breached. Despite privately funded therapeutic rehabilitation being provided, he never engaged with substance misuse services and maintained a strong sense of entitlement that his mother should be financially supporting him.

1.4 Although the victim continually tried to get her son the help he needed, she had to be awarded a restraining order for her own protection. By turning up at his grandparent's home, the perpetrator was seen to possibly manipulate his mother into taking him home, where he went on to kill her whilst she was helping him to seek services. He was convicted of manslaughter with diminished responsibility.

2. Summary of the Review Process

2.1 The decision to undertake a domestic homicide review was made by the Chair of East Sussex Safer Communities Partnership and the Home Office was notified of the decision on 29/10/2018. An independent chair and review panel were appointed, and the review was managed in accordance with the relevant statutory guidance.

2.2 The review panel members are listed in Appendix A and included representation from Change Grow Live (CGL) who provide both domestic abuse and substance misuse services in the local area. They were able therefore to add a specialist perspective on domestic abuse as well as expertise on substance use, which was an important feature of this review. The panel members were all independent of the particular case.

2.3 The process began with an initial meeting of the review panel in April 2019. Terms of reference were drawn up and incorporated key lines of enquiry as featured in Appendix B. Agencies participating in this review are featured in Appendix C as well as those who had no contact.

2.4 The review panel met on four occasions and the Independent Chair contacted family and work colleagues of the victim and met with one family member. Family members contributed to the terms of reference and were given the opportunity to comment upon the draft Overview Report before it was finalised.

2.5 The Overview Report was endorsed by East Sussex Safer Communities Partnership in 26/11/2020 before being submitted to the Home Office for approval.

3. Key Findings

3.1 Whilst the perpetrator repeated acquisitive crimes and manipulated his extended family in order to fund his use of illicit drugs and alcohol, he particularly targeted his mother for burglary, theft and aggressive demands for money. Indeed, he had a sense of entitlement that his mother should be providing him with money. Although the family's relative affluence may have obscured the economic abuse, the review demonstrated that domestic abuse is not class-specific and concluded that practitioners need to be curious and open to the possibility of economic abuse,

particularly because it rarely happens in isolation. If economic abuse is missed, we may be missing the opportunity to uncover other possible forms of coercive control and domestic abuse.

3.2 The extent of the domestic abuse and coercive control was not known, but when the victim attended health settings, there were missed opportunities for routine enquiry into domestic abuse.

3.3 Although the perpetrator recognised the detrimental impact of substance use on his mental health, he was not motivated to address his problematic alcohol and drug use. After a thorough mental health assessment, he was found to display symptoms of anxiety but was not diagnosed with an acute or enduring mental illness that would require secondary mental health care treatment and so it was right that he was not considered for services for dual diagnosis. It was clear that mental health services consistently encouraged the perpetrator to seek treatment, although other opportunities were missed to refer him, both whilst he was in custody in London and when probation services delayed in requiring his engagement with substance misuse services as part of his sentence. These delays arose as the ownership of his case ping-ponged between two community rehabilitation companies.

3.4 The perpetrator's most serious offending spanned a relatively short period of time during which he was arrested three times. At times the level of risk was minimised by both police and probation and probation services did not take the action necessary to hold the perpetrator to account for his breach of community orders.

3.5 Despite some agency shortcomings, the review identified good practice amongst agencies including:

- The liaison between the hospital and police, and the police's mobilisation to find the perpetrator when he went missing from hospital in 2016 demonstrated a commitment to find a vulnerable young man at risk.
- Adult Social Care moved quickly to attempt to offer the victim a carer's assessment before her son's mental health had been fully assessed, demonstrating a commitment to early intervention.

- Despite many indications leading to the conclusion that the perpetrator's first significant episode had been a consequence of substance misuse, Sussex Partnership NHS Foundation Trust provided a robust assessment of his mental health over several months to ensure that there was no underlying mental ill-health.
- The integrated homeless service at University College London Hospital was able to provide a seamless service to the perpetrator when he was homeless and attending hospital in 2017.
- The GP made the perpetrator a temporary patient and saw him quickly when referred by acute mental health services in 2018 enabling him to access mental health services at a primary care level.

3.6 In the final instance, the victim appeared to feel obliged to have her son return home despite a restraining order preventing his contact and she tried to seek help for his worsening mental state. Whilst the hospital and a mental health service knew about the restraining order, it was questioned whether they may have been more concerned about an abused woman returning home with an abusive partner than an abusive son. It is the responsibility of all agencies to reinforce measures, such as restraining orders, which are taken against domestic abuse perpetrators, and staff need to be supported to undertake this safely.

3.7 The review identified that domestic abuse in the context of child-to-parent abuse is perhaps less understood than domestic abuse within intimate partner relationships and there are particular barriers that parents, and mothers in particular, face. This review provided further evidence of some of the key indicators of risk associated with domestic homicide including an abuser having suicidal thoughts, issues with addiction and a sense of entitlement to financial resources. However, practitioners need to better understand child-to-parent abuse and ensure that their assessment of risk is not minimised by unconscious bias about the nature of the relationship.

4. Recommendations

4.1 Overview Recommendations

Recommendation 1: Coercive Control

East Sussex Safer Communities Partnership should promote public and professional awareness of economic abuse as a method of coercive control within domestic and familial abuse. They should seek assurance from its agencies that they have enacted the new definition of economic abuse within their policies and practice.

Recommendation 2: Child-to-Parent Abuse

East Sussex Safer Communities Partnership should seek assurance from its agencies that front-line practitioners are sufficiently supported through training, guidance and supervision to be able to respond effectively to child-parent abuse, irrespective of the various ages of those abusing and abused.

Where gaps emerge, East Sussex Safer Communities Partnership should consider what needs to be done collectively with agencies to raise the awareness and expertise of practitioners to respond to child-parent abuse.

Recommendation 3

East Sussex Safer Communities Partnership should increase public awareness about child-parent abuse and the role of specialist domestic abuse services in supporting those affected

Recommendation 4: Pre-Sentence Reports for Domestic Abuse Offences (National)

The Ministry of Justice is asked to consider whether a standard should be set for pre-sentence reports involving domestic abuse, including those pre-sentence reports which are required verbally and 'on the day', to routinely include evidence of police reports, necessitating the time being allocated for them to be carried out.

4.2 Individual Agency Recommendations

Sussex Clinical Commissioning Groups

The CCG to continue to promote the importance of routine enquiry regarding domestic abuse across primary care.

Health professionals to have awareness of the impact of supporting a family member who has care and support needs. Further training for all staff to be considered on what the impact is on the wider family / carer / support system. Consider placing a flag or note on the electronic patient record system as a reminder to approach how the carer is feeling and to ask if they have any concerns regarding their personal safety.

Kent and Medway Partnership Trust

Any disclosure of 'a protective' 'restraining' 'police' or other order including tags etc must be explored for the reason why this has been put in place, this includes making contact to the police to report a breach.

To increase confidence amongst KMPT staff regarding routine enquiry around domestic abuse.

Kent Surrey and Sussex Community Rehabilitation Company

KSS CRC to improve their practice around case transfers.

Maidstone and Tunbridge Wells NHS Trust

Identify actions in the updated version of the Domestic Abuse Policy and Procedure to inform staff what actions are required when a patient states they are going to be discharged to live with the perpetrator and there is a restraining order in relation to living or being near to the perpetrator, that staff should inform the police that this is likely/going to occur.

National Probation Service Sussex

A further reminder to Sussex CDOs that following breach hearings, if order continues, the CDO must make efforts to give a reporting appointment before the offender/ service user leaves court. CRC, if asking for orders to continue, will also ensure appointments are detailed within the breach report where possible, or an appointment date advised once a breach hearing date is known, either directly to NPS Court Team or to the CRC staff member attending Breach Court in support of the process. If an offender fails to attend a Breach hearing and subsequently attends on warrant, NPS Court staff must take all reasonable steps to secure an appointment date and time.

NPS to continue to apply national allocation process.

Court report writers to check call out information when the offending is linked to family members and or grievances involved. All court staff, over the following year, will be undertaking unconscious bias training as provided by the Civil Service. As part of our continuous professional practice events, Court report writers will continue to apply reflective practice approaches to discuss potential risk issues around similar cases.

Priory Group, Priory Hospital North London

During the discharge process, clarity should be given to family, carers and professionals in respect of risk. A telephone contact with the patient will be made within 48 hours of discharge and a discharge letter will be sent to all those involved with the patient's care with 7 days.

On admission, each patient should receive a comprehensive joint risk assessment by nursing and medical colleagues which needs to be documented on their care records. This will include an assessment of risk and establishment of observation level.

Sussex Police

That Sussex Police conduct an audit to ensure that history markers are being applied consistently and appropriately in cases involving allegations of domestic abuse.

Appendix A: Review Panel Members

Name	Role/Organisation
Paula Harding	Independent Chair
Alison Cooke	Named Nurse Adult Safeguarding, Sussex Community NHS Foundation Trust
Bryan Lynch	Deputy Director of Social Work, Sussex Partnership NHS Foundation Trust
Domenica Basini	Assistant Director for Safeguarding and Quality, NHS England
Gillian Field	Designated Nurse Safeguarding Adults, Sussex Clinical Commissioning Groups
Jane Wooderson	Detective Sergeant, Safeguarding Review Team, Sussex Police
Karen Davies	Matron Safeguarding Adults, Maidstone and Tunbridge Wells NHS Trust
Karen Perrier	Client Service Manager, Money Advice Plus
Lee Whitmore	Assistant Chief Probation Officer, Kent Surrey and Sussex Community Rehabilitation Company
Leigh Prudente	Head of Service, East Sussex Adult Social Care
Lindsay Adams	Strategic Commissioner, East Sussex County Council
Michaela Richards	Director of Operations South-East, Change, Grow, Live
Debbie King	Head of Service, The Portal (multi-agency domestic and sexual abuse and Independent Domestic Violence Advisor Service), Change Grow Live
Natasha Gamble	Partnership Officer for Domestic, Sexual Abuse and Violence, Joint Domestic, Sexual Violence & Abuse and Violence against Women & Girls (VAWG) Unit Brighton & Hove and East Sussex

Appendix B: Key Lines of Enquiry

The review sought to address both the 'circumstances of particular concern' set out in the Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews (2016) and the following specific issues identified in this particular case:

- Analyse key episodes in agencies' response including the nature of assessments, decision making and responses and whether they met the expected standards of practice and procedures.
- Analyse how agencies engaged with the perpetrator in respect of assessments, services or supervision orders and responded when they were unable to engage.
- How was the perpetrator's alcohol and drug use understood in relation to his care needs and risk to himself and others?
- Analyse the opportunity for agencies to routinely enquire, identify, assess and respond to domestic abuse or public protection risk, threat and needs.
- Analyse how organisations accessed or worked with specialist domestic abuse and substance misuse agencies in this case.
- Analyse any delays in providing a service to the victim or perpetrator
- Was the victim identified as a formal or informal carer? How did agencies involve the victim in assessments of her son and what opportunities were there to have a formal or informal carer's assessment about her needs and responsibilities?
- How robust was multi-agency working? Analyse how effectively agencies worked together to share information, assess, make decisions and respond to the risks, threats and needs of the victim, perpetrator and wider family. Were joint working protocols themselves robust?
- How well did agencies know the terms of restraining/non-molestation order, anti-social behaviour injunction and the suspended sentence order, and respond to any perceived breaches of these terms?
- Analyse the policies, procedures, supervision, support and training available to the agencies involved on domestic abuse issues, including familial abuse.
- To outline each agency process and practice in generating or responding to a Single Agency Combined Assessment of Risk (SCARF)

GPs were asked to specifically consider:

- Where was the perpetrator registered with primary care and the periods of his registration?
- How the perpetrator disclosed his substance misuse and what opportunities there were to engage him in treatment?
- How the perpetrator's mental health was understood and whether secondary mental health services were engaged in his diagnosis or treatment?
- Whether the victim raised concerns about her son and how these concerns were responded to.
- Whether the victim disclosed violence and abuse from her son or, if not, whether there were opportunities to make further or routine enquiry with her?
- Whether the GP practices have robust staff training, procedures and pathways for clinical or routine enquiry and responses to domestic violence and abuse?

Appendix C: Agency Involvement in the Review

Individual management reviews and chronologies were requested from the following organisations:

- General Practitioners
- Kent and Medway Partnership Trust
- Kent, Surrey & Sussex Community Rehabilitation Company
- London Community Rehabilitation Company
- Metropolitan Police
- Sussex Partnership NHS Foundation Trust
- Sussex Police

The following agencies had less involvement and were asked to provide briefer reports and chronologies:

- East Sussex County Council Adult Social Care and Health
- British Transport Police
- Camden and Islington NHS Foundation Trust
- Sussex Community NHS Foundation Trust
- Kent Police
- Maidstone and Tunbridge Wells NHS Trust
- Priory Hospital
- Surrey Police
- University College Hospital London

The following agencies were contacted but confirmed that the victim or perpetrator were not known to them:

- East Sussex Drug and Alcohol Service (STAR)
- East Sussex Healthcare NHS Trust (community children's health)
- East Sussex Multi Agency Risk Assessment Conference
- Optivo Housing Association
- Refuge (domestic abuse service)
- SWIFT Specialist Family Services
- Wealden District Council (housing services)