Domestic Homicide Review Executive Summary

Commissioned By Southampton Safe City Partnership

Under s9 of the Domestic Violence Crime and Victims Act 2004

In respect of the death of ‘Peter’ who died in February 2020

Review Author and Independent Chair: Jan Pickles OBE

Date report completed: 21.06.22.

Contents

1.THE REVIEW PROCESS 3
2.CONTRIBUTORS TO THE REVIEW 5
3.THE REVIEW PANEL MEMBERS 5
4.AUTHOR OF THE OVERVIEW REPORT 7
5.TERMS OF REFERENCE FOR THE REVIEW 7
6.SUMMARY CHRONOLOGY 9
7.KEY ISSUES ARISING FROM THE REVIEW 13
8.CONCLUSIONS 15
9.LESSONS TO BE LEARNT 16
10.RECOMMENDATIONS FROM THE REVIEW 17

1. THE REVIEW PROCESS

1.1 This Executive Summary outlines the process undertaken by Southampton Safe City Partnership Domestic Homicide Review Panel in reviewing the death of Peter. In February 2020 Peter was killed by his son Edward at the flat they shared in Southampton. Following Edward's arrest this case was referred to the Southampton Safe City Partnership[1] by Hampshire Constabulary for consideration of a Domestic Homicide Review (DHR). A decision was taken by Southampton Safe City Partnership to instigate a DHR in March 2020 and the Coroner was informed.

1.2 The following pseudonyms were agreed by Peter's older son for use in this review for the deceased and his brother Edward to protect their identities and that of their family members.

1.3 In terms of the Protected Characteristics within the Equality Act 2010, Peter (male) was 70 years old at the time of his death in February 2020 he identified as White British and no significant physical or mental health difficulties.

1.4 In terms of Edward (male) and the Protected Characteristics within the Equality Act 2010, he identifies as White British was 28 years old at the time of the Manslaughter and was receiving treatment for his mental health.

1.5 Despite being an infrequent crime, parental homicide has been associated with schizophrenia spectrum disorders in adult perpetrators and a history of child abuse and family violence in adolescent perpetrators. Among severe psychiatric disorders there is initial evidence that delusional misidentification might also play a role in patricide.[2] The family have stated that Edward had witnessed domestic abuse in his parents' relationship as a child and at the time he killed his father believed him to be in a sexual relationship with his girlfriend.

1.6 Eighteen agencies that potentially had contact with Peter prior to the point of death were contacted and asked to confirm whether they were involved with him or his son Edward. Seven of the agencies contacted confirmed contact with Edward and his brothers Peter and James and were asked to secure their files.

1.7 The Chair was appointed in August 2020 with the inaugural meeting of the Review Panel in September 2020. The initial scoping identified that nine agencies held relevant information. The DHR was concluded in June 2022. This Review was delayed by the COVID-19 pandemic as it occurred a month prior to the national lockdown and once commenced agencies required a longer period to complete their Individual Management Reports (IMRs). The Serious Incident report commissioned by Southern NHS Trust was shared with the panel in July 2021.The Panel were informed in October 2021 that Public Health England were to review Peter's case

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[1] The Safe City Partnership is a statutory partnership that brings together organisations and commissioners with responsibility for keeping people safe.

[2] Patricide and overkill: a review of the literature S Trotta, G Mandarelli & D Ferorelli & B Solarino Forensic Science, Medicine and Pathology (2021) 17:271–278 Patricide_and_overkill_a_review_of_the_literature_.pdf

and so paused. In May 2022 the Panel learnt that this review has not yet started and so concluded the DHR to avoid further delay.

1.8 Family contact - Peter's older son as his next of kin was supported throughout this process by a member of the Victim Support Homicide Team and during the Criminal Justice process by a Family Liaison Officer (FLO). Following the initial DHR Panel meeting in September 2020 the Chair contacted the Victim's Support Homicide Team who were already providing support to Peter's family. They had received leaflets and information on the DHR process. The Chair spoke initially to Peter's older son and Peter's ex-partner the mother of his two sons. At that time, they were preoccupied dealing with their concerns with the Serious Incident Report prepared by Health agencies and we agreed to speak after that was finalised. At the beginning of 2021, the Chair continued to communicate with both and had virtual meetings with them separately. In June 2021 his son attended the DHR Panel and provided a moving description of the impact this tragedy had on the entire family he was able to challenge and seek assurance. The Panel's view is that this Review has benefitted from his involvement. In August 2021 once the Covid restrictions were lifted, the Chair met face to face with Edward's mother. Their views are contained in this report and draft recommendations were discussed with Peter's older son and next of kin in October 2021. At this point the family and Panel felt it appropriate to pause the review to allow Public Health England to conduct their Review. The final draft of this DHR was shared with Peter's older son and ex-partner in July 2022, and their comments included. A brief video was made for professionals by the Chair and Peter's ex-partner on his case and shared at Learning events.

1.9 Edward was in a relationship with a girlfriend in the year prior to Peter's death and an offer was made to her via Edward's mother who she remains in regular contact with to participate in this review, but she chose not to. In her Victim Impact Statement his then girlfriend said she had subsequently suffered from post-traumatic stress disorder because of this experience and the Panel agreed not pursue further contact whilst the offer remained open to her throughout this process.

1.10 Outcome of the Criminal Justice process - Edward appeared at Winchester Crown Court in September 2020, he was sentenced to a Hospital Order with restrictions under Section 37/41 of the Mental Health Act 1983 without limitation of time and has also been allocated under the Multi Agency Public Protection Arrangements (MAPPA) as a Category 2 MAPPA nominal.

1.11 Contact with the perpetrator Edward - Following Edward's detention under the Mental Health Act the Chair with Edward's mother and Clinician's permission had a brief conversation with Edward in February 2021. Edward expressed great remorse and regret at the death of his father. He believes that it would have been beneficial that a strategy to help him when he was ill should have been agreed when he was well between himself, the agencies involved and his family. In August 2021, the Chair spoke again with Edwards Consultant as it was felt that he may have more to

say to aid the Review. A visit was undertaken but, on the day, he did not feel well enough to meet with the Chair who was able to speak with staff on the ward.

2 CONTRIBUTORS TO THE REVIEW

2.1 Scoping requests were made to 18 agencies:

1. Southampton City CCG
2. Solent NHS Trust
3. Hampshire Constabulary
4. University Hospital Southampton NHS Foundation Trust
5. Southampton City Council – Housing & Homelessness
6. Southampton City Council – Environmental Health
7. Southampton City Council – IDVA
8. Southampton City Council – Adult Social Care
9. Southern Health NHS Foundation Trust – Mental Health
10. Victim Support
11. Yellow Door
12. Aurora New Dawn
13. Hampshire Liaison Diversion Service
14. South Central Ambulance Service
15. Vivid Housing
16. National Probation Service
17. The Hampton Trust - Domestic Abuse provider
18. CGL - Substance Abuse provider

2.2 From this the Panel identified seven agencies with relevant information who were then asked to provide a full IMR. These IMR's were completed by a member of staff who had not had contact directly or undertaken an immediate line management:

1. Solent NHS Trust
2. Southampton City Council – Adult Social Care
3. Southern Health NHS Foundation Trust – Mental Health
4. Southampton City Council -Housing
5. Hampshire Constabulary
6. Southampton City CCG
7. University Hospital Southampton NHS Foundation Trust

3 THE REVIEW PANEL MEMBER

3.1 The following agencies were invited to be part of the DHR Panel. All members were representatives of their respective organisations and had had no direct or line management responsibility for services provided to Edward and his family.

Agency Representative	Name	Role

Independent Chair	Jan Pickles	Chair and Author
Southern Health NHS Foundation Trust	Adam Cox	Clinical Director for Southampton Division & Crisis Team consultant
Southern Health NHS Foundation Trust	Liz Hall	Head of Patient Services
Southern Health NHS Foundation Trust	Caz Maclean	Associate Director of Safeguarding
Southern Health NHS Foundation Trust	Claire Fulker	Safeguarding Specialist Practitioner
Solent NHS Trust	Fiona Holder Karen Davies	Head of Safeguarding Lead Nurse for Adult Safeguarding for Solent NHS Trust
Southampton City Council	Karen Marsh	DSA Manager- IDVA Service Manager
University Hospital Southampton NHS Foundation Trust	Ann Rodwell	Adult Safeguarding Nurse Specialist
National Probation Service	Jenny Mckie	Attended the inaugural meeting then stood down by the panel
Southampton City Council	Sandra Jerrim	Senior Commissioner Integrated Commissioning Service
Southampton City Council	Martin Buckmaster	Deputy Manager Homelessness
Southampton City Council	Amy Bradley	Approved Mental Health Professional Team Manager
Southampton CCG	Siobhan West Lindsay Voss	Designated Nurse for Safeguarding
The Hampton Trust	Chantal Hughes	CEO

Southampton City Council	Eric Smith	Adult Safeguarding Team Manager
Southampton City Council	Kerry Owens	Assistant Domestic & Sexual Abuse Co-ordinator Adults Housing & Communities
Hampshire Constabulary	Grace Mason Bryan Carter	Serious Case Reviewer

3.2 The Senior Investigating Officer, a Detective Chief Inspector from Hampshire Constabulary attended the Panel meeting in September 2020 to brief the panel on the Police investigation.

4 AUTHOR OF THE OVERVIEW REPORT

4.1 Jan Pickles OBE was appointed as Independent Chair of the DHR and author of this report in August 2020. She is a qualified and registered social worker with over forty years' experience of working with perpetrators and victims of domestic abuse, coercive control, and sexual violence, both operationally and in a strategic capacity. In 2004, she received an OBE for services to victims of domestic abuse for the development of both the Multi Agency Risk Assessment Conference (MARAC) model and for the. She has completed the Home Office training for chairs and authors of Domestic Homicide Reviews. Jan Pickles is not currently employed by any of the statutory agencies involved in the Review (as identified in section 9 of the Act) and have had no previous involvement or contact with the family or any of the other parties involved in the events under Review.

5 TERMS OF REFERENCE FOR THE REVIEW

5.1 Introduction - This Domestic Homicide Review is commissioned by the Southampton Safe City Partnership in response to the homicide of Peter in February 2020. This Domestic Homicide Review (DHR) was commissioned because it meets the definition detailed in paragraph 12 of the Multi-Agency Guidance for the Conduct of Domestic Homicide Reviews (Home Office 2016). The review will follow the Statutory Guidance for Domestic Homicide Reviews under the Domestic Violence, Crime and Victims Act 2004.

5.2 Purpose of the review

- Establish the facts that led to the incident in February 2020 and whether there are any lessons to be learned from the case about the way in which professionals and agencies worked together to safeguard the family.
- Identify what those lessons are, how they will be acted upon and what is expected to change as a result.
- Apply these lessons to service responses including changes to policies and procedures as appropriate.

- Prevent domestic violence and abuse homicide and improve service responses for all domestic violence and abuse victims and their children through improved intra and inter-agency working.
- Establish the facts that led to the incident and whether there are any lessons to be learned from the case about the way in which local professionals and agencies worked together to support or manage the perpetrator. Domestic Homicide Reviews are not inquiries into how the victim died or who is culpable. That is a matter for coroners and criminal courts.

5.3 Scope of the review

- Consider the period from Feb 2016 to February 2020 subject to any information emerging that prompts a review of any earlier incidents or events that are relevant.
- Request Individual Management Reviews by each of the agencies defined in Section 9 of the Act and invite responses from any other relevant agencies or individuals identified through the process of the review.
- Seek the involvement of the family, employers, neighbours & friends to provide a robust analysis of the events.
- Take account of the coroners' inquest in terms of timing and contact with the family.
- Produce a report which summarises the chronology of the events, including the actions of involved agencies, analysis and comments on the actions taken and makes any required recommendations regarding safeguarding of families and children where domestic abuse is a feature.
- Aim to produce the report within six months after completion of the criminal proceedings, responding sensitively to the concerns of the family, particularly in relation to the inquest process, the individual management reviews being completed and the potential for identifying matters which may require further review.

5.4 In addition, the following areas will be addressed in the Individual Management Reviews and the Overview Report:

- Was the victim known to domestic abuse services, was the incident a one off or were there any warning signs. Could more be done to raise awareness of services available to victims of domestic abuse?
- Was the perpetrator known to domestic abuse services, was the incident a one off or were there any warning signs.
- Were there any barriers experienced by the victim or family, friends, and colleagues in reporting the abuse.
- Where there any opportunities for professionals to routinely enquire as to any domestic abuse experienced by the victim that were missed?

- Are there any training or awareness raising requirements that are necessary to ensure a greater knowledge and understanding of the services available?
- Consider any equality and diversity issues that appear pertinent to the victim, perpetrator.
- Was the alleged perpetrator known to have a history of DA, if so, what support was offered to the perpetrator?
- Were staff working with the alleged perpetrator confident around what service provision is available around DA locally?
- Consider any equality and diversity issues that appear pertinent to the perpetrator?

5.5 Family involvement - The review will seek to involve the family of both the victim and the perpetrator in the review process, taking account of who the family wish to have involved as lead members and to identify other people they think relevant to the review process. We will seek to agree a communication strategy that keeps the families informed, if they so wish, throughout the process. We will be sensitive to their wishes, their need for support and any existing arrangements that are in place to do this we will identify the timescale and process of the coroner's inquest and ensure that the family are able to respond to this review and the inquest avoiding duplication of effort and without undue pressure.

5.6 Legal advice and costs - Each statutory agency will be expected and reminded to inform their legal departments that the review is taking place. Each statutory agency may seek their own legal advice at their own discretion and cost.

5.7 Panel members, expert witnesses, and advisors - At the time of drafting these Terms of Reference the Panel are confident its membership has specific expertise in domestic abuse but as the review progresses it may identify specific areas of expertise required and will seek this expertise if necessary.

5.8 Media and communication - The management of all media and communication matters will be through a joint team drawn from the statutory partners involved. There will be no presumption to inform the public via the media that a review is being held to protect the family from any unwanted media attention. An executive summary of the review will be published on the CSP website, with an appropriate press statement available to respond to any enquiries. The recommendations of the review will be distributed through the CSP website and applied to any other learning opportunities with partner agencies involved with responding to domestic abuse.

6 SUMMARY CHRONOLOGY

6.1 Peter was aged seventy at the time of his death in February 2020. He was the father of Edward and his brother; he had six children from a previous relationship with whom we believe he had no contact. Peter had separated from Edward's

mother when Edward was about five years old. Peter remained in Southampton after the separation but saw little of his sons until they were teenagers. Peter had worked as a long-distance lorry driver prior to his retirement, he was known to experience occupational related health problems in terms of his mobility and joint pain. Peter had little contact with agencies; both his ex-partner and son describe him as someone who did not seek help from services. We do know that as Edward's behaviour deteriorated his father became more involved in supporting him, providing, and helping him to find accommodation, advice and occasionally contacting agencies trying to get help for him.

6.2 Some behavioural difficulties were noted at school in relation to Edward, and his mother feels these may have been an early sign of his future difficulties. Edward was described by his mother and brother as a caring and generous child and was never violent. As an adult Edward's relationship with his father was often poor. After separation, Edward's mother began a new relationship which became violent and abusive. It is believed that Edward and his brother witnessed this abuse. As an adult Edward moved between his parents, and often when close with one was distant with the other. Edward later became convinced that his father was having an affair with his girlfriend. Despite the sometimes-strained relationship with their father both siblings loved him, and Edward remains bereft that he killed him.

6.3 Edward was first arrested in 2005 and sporadically thereafter for low level crime which developed into more serious offending including drug related and burglary. From 2016 onwards Hampshire Constabulary's contact with Edward was primarily due to the behaviours linked to his mental health issues described below.

6.4 In July 2016 while Edward was on holiday in Ibiza with friends and he experienced what was later identified as a 'psychotic episode' in which he became paranoid, believing that people were following him. It is reported that Edward climbed onto the hotel roof he was staying at to 'escape' from them. It seems the trigger for this episode was his use of methylenedioxymethamphetamine (MDMA or ecstasy) and cannabis. These symptoms were to continue on his return to the UK.

6.5 This event was soon followed by two further serious incidents in August and September 2016, at his father's and his mother's flats. Both incidents involved Edward climbing onto the roofs of buildings and threatening to jump. In the first incident he carried out his threat, sustaining serious injuries, an on call mental health worker felt the act to have been a serious attempt by Edward to kill himself. In the second incident Edward was successfully persuaded to leave the roof after many hours and was taken to Hospital and was detained under Section 2 of the Mental Health Act following assessment in which he was identified as 'High Risk' to self and to be experiencing a 'Psychotic episode'. It was agreed between the Duty Mental Health Social Worker and the Adult Safeguarding Duty Social Worker that Edward

did not meet the threshold for a Section 423 triage but did have care and support needs that could be met by Community Mental Health Services, and a referral was made to them. This second event had been preceded the day before with Edward's mother and brother taking him first to the Central Police Station and then to the A&E Unit as they feared he would take his life. They were unable to get help, and due to Edward's behaviour and fear that Edward had a knife they took him home. The following morning Edward was taken to hospital and was detained under Section 2 of the Mental Health Act to a Solent NHS facility.

6.6 Edward was discharged to his mother's address at the end of September 2016. He was diagnosed with a Psychotic Disorder. Care was transferred to the two weeks later to Adult Mental Health Team (AMHT) and Early Intervention Psychosis (EIP) in mid-October 2016. It was established that Edward's behaviour from the first incident on holiday onwards stemmed from his belief that he had witnessed a violent incident- whether a murder or stabbing is not clear in 2015 and that he felt he was at risk of being murdered because of this.

6.7 Edwards compliance with the treatment plan agreed on his discharge was poor. In mid-February 2017, Edward's mother disclosed her concerns at his deterioration, outbursts of anger and aggression and non-compliance with medication. Edward's mother stated she was 'intimidated' by him, expressing her fear of him if he should find out she had contacted the Mental Health Team. She also disclosed Edward's drug use and that he carried a knife. He was assessed at home In mid-February 2017. A Mental Health Act (MHA 1983), assessment was undertaken, and he was assessed as well enough to remain at home. However, Edward's poor engagement continued, he was known to be non- compliant with medication, missed appointments with clinicians. Given his poor compliance, consideration was given to discharging Edward by the CMHT, but this was overtaken by a subsequent serious incident.

6.8 In April 2017 Edward threatened to burn down his mother's flat after an argument with her in which she told him to leave. Hampshire Police attended, and a notification was sent to the MASH. The Police IMR states that a DASH was completed, and risk of harm assessed as 'Medium'. However, Edward's mother states that during the police attendance she was never spoken to individually and was not aware of a DASH being completed, neither she, nor Edward's brother, who was also present were aware the incident was seen as one of 'domestic abuse.'

[3] The Care Act 2014 (Section 42) requires that each local authority must make enquiries, or cause others to do so, if it believes an adult is experiencing, or is at risk of, abuse or neglect. An enquiry should establish whether any action needs to be taken to prevent or stop abuse or neglect, and if so, by whom. 'Safeguarding adults' is the name given to the multi-agency response used to protect adults with care and support needs from abuse and neglect. When an allegation about abuse or neglect has been made, an enquiry is undertaken to find out what, if anything, has happened. The findings from the enquiry are used to decide whether abuse has taken place and whether the adult at risk needs a protection plan. A protection plan is a list of arrangements that are required to keep the person safe.

6.9 A month later, Hampshire Constabulary were called to a disturbance at the flat of Edward's father. Edward was armed with a knife and a piece of broken glass and was threatening his father and brother with those. When police officers arrived, Edward attempted to throw himself out of the window. He was caught hanging out of the window and was seen cutting at his neck and arms with the knife. Edward was restrained and made safe. Peter was offered but rejected added security. A DASH was completed, and Peter was assessed as at 'Medium Risk.' This was despite Edward's use of weapons (broken glass and a knife) and his known use of drugs. Hampshire Constabulary records state that "The level of harm he (Edward) was prepared to do to himself was known to be at the higher risk end of self-harm" It was also noted that the parents likely minimised the risk they themselves were at. Edward was admitted to a local hospital under Section 3 of the Mental Health Act. On admission it was recorded that he had "been hearing voices, messages from the TV, carrying knives to protect himself, has been using cannabis daily." He said he had not slept in four days. A day later Edward assaulted a worker at the Hospital. Police records indicate that Edward was not charged with this assault partly in line with the victims wishes, but also due to the belied that successful conviction may have been unlikely due to 'fluctuating capacity' issues. The Panel have been informed that Hospital policy has now changed and that all assaults on staff are vigorously pursued. From July 2017 to late March 2018 there were numerous contacts between Edward and the Early Intervention in Psychosis (EIP) Team from Southern Health NHS Foundation Trust's Mental Health Service, and others involved in Edward's medical care. There is a pattern to these contacts, which were mostly Home Visits, during which Edward in large part remained living with his father. His smoking cannabis and his intrusive thoughts, anxiety and paranoia continued to be a concern to medical staff. His compliance with the medical oversight he was subject to again deteriorated and he began asking for a discharge from EIP care. His father was reported to be positive about his son's progress. His brother has told the Panel that his father believed he and Edward could manage these issues by themselves and was actively discouraging interventions. In late March 2018 Edward "discharged himself against medical advice".

6.10 At the end of May 2018, Edward travelled to London and was arrested by the Metropolitan Police after his behaviour- he was attempting to climb a building had triggered an 'Armed Response Unit' being called out. A Hospital Order was put in place. Edward was moved to a semi-independent unit close to the Hospital. He remained there until mid-September 2018 and was discharged to his father's flat at his request. He was still identified to have symptoms suggestive of psychosis-. 'hearing 'noises' and believing people were 'after him,' but that despite these he stated he felt well'. The Consultant identified the risk as "low right now, psychosis still present but in the background now." He was seen in a home visit in early May 2019 in which he refused offers of support saying he did not need them, that he was happy living as he was, had stopped his medication and did not need CBT. This pattern of limited compliance continued. In 2019 Edward's relationship with his

girlfriend began, and by early 2020 was to begin to believe his father was having an affair with her.

6.11 In early January 2020, Edward's father contacted EIP concerned about his son's behaviour and mental health. This was in itself an unusual step as Peter had always been reluctant to involve others in their family life. He described to the call handler that his son had accused him of having an affair with his girlfriend and being verbally aggressive to him. The call handler described Peter as being 'upset'. The call handler then contacted Edward's mother who said she could not speak as Edward was there. The call handler described her voice as 'shaky' and that when the call handler spoke to Edward he was 'suspicious.' In a later Home Visit by EIP workers, Edward's mother disclosed that early January 2020 Edward had made threats to kill his father, believing him to be having sex with his girlfriend, and that he had some months ago accused his girlfriend of having sex with another man. There is no record of these threats being recorded, a DASH completed or of the information being passed on to the police, although they represented a specific threat to both Edward's father and Edward's girlfriend. The plan made following this visit was to transfer care to the Acute Mental Health Team (AMHT) and arrange a 'joint family visit,' neither potential victim was warned.

6.12 Over the next month Edward's father contacted Hampshire Constabulary to report Edward missing and disclosed that he had been verbally aggressive to him and threatened to take his money and beat him up. This was not recognised as economic abuse. Then some days later the Police were called after Edward made threats to kill his brother and had then left the house. He was found later by a police officer in the town centre, registering as homeless. A visit to the family home was arranged for the following day but was unable to be conducted due to operational demands. A telephone call was made to Edward's mother to apologise for the absence of a visit. Edward was spoken to; he refuted the Threats to Kill allegation describing the incident as a 'verbal only domestic'. Edward was also seen by an officer, and indicated it was a "family argument that was blown out of proportion." There was no further contact with Edward or his family until early February 2020 when police were called to Peter's flat where his body was found.

7 KEY ISSUES ARISING FROM THE REVIEW

7.1 One of the most striking features of this case is the apparent lack of multi-agency working and poor information sharing between agencies in Southampton that were working with Edward and his family. Emblematic of this is the approach revealed within the IMR from Solent NHS Trust which stated that "There are no indicators or disclosures of harm or Domestic Abuse during any episodes of care provided to Edward or Peter." It seems that no link was made between Edward's psychotic episodes, his extreme behaviour and risks he could present to family members with whom he was living. Edward's family, in particular his mother contacted mental health services several times from the first incident in 2016 to the manslaughter of Peter in February 2020 to inform them of her fears of living with

Edward. Edward's mother told the Mental Health Team worker during a home visit in February 2017 that she was 'intimidated' by Edward and expressed her fear of him should he find out she had spoken to them. She also told them that he carried a knife and that he took it to bed with him. These threats and the specific threat made by Edward during a home visit to the two Community Mental Health Team workers regarding his father and the telephone call in which Peter reported Edward's threat to kill him were not reported to the police, instead Southern Health restricted action to advising Edward's mother to call 999 if she felt unsafe. It seems the fear expressed by Edward's mother were implicitly discounted and that despite risk indicators being present including continued non-compliance with treatment, drug misuse and poor compliance, that Southern Health failed to recognise that this was a case of Intra-Familial Domestic Abuse (IFA) or Adult Family Violence (AFV). This failure to recognise AFV is not unique to services in Southampton, 'Standing Together' in their recent research found several examples of similar practice. One can only assume that the views and fears of Edward's family of his threats, deterioration in behaviour were not considered as seriously as those of the professionals working with them.

7.2 The views of his family do not appear to have been considered. Edward's mother consistently expressed fear of Edward, yet it was deemed safe for him to return home to them, despite threats to his family and his carrying of knives.

7.3 The family were offered neither advice nor support in terms of their managing the threat of domestic abuse from Edward despite two call outs in which DASH's were completed by police officers and risk identified as 'Medium' by Hampshire Constabulary. Assessment was hampered by lack of information sharing from other agencies in particular Southern Health- a telling example of this their failure to share Edward's assault of a member of staff whilst in hospital in May 2017. During these incidents it is not clear that there was a sufficient victim focus- firstly whether Edward's mother was interviewed separately by police officers attending the incident, and secondly whether Edward's father who turned down added security measures and was seen as probably minimising the danger to him was not more strongly advised to reconsider his refusal of help by officers attending. Edward's belief that his father was having an affair with his girl friend putting her at risk and increasingly so as his condition deteriorated although reported to Community Mental Health workers from early 2020 and stated directly to them on a home visit by Edward was never acted upon nor shared with the Hampshire Constabulary.

7.4 What is striking to the Panel is the absence of the involvement of Adult Social Care and Safeguarding Services through all these events involving Edward and his family. This is a factor which the 'Standing Together' research identifies as common in cases such as these. The document states," The curious near-systematic invisibility of Adult Social Care (through lack of referrals or NFA taken by ASC), and internal Adult Safeguarding processes was striking, even though most of the individuals concerned were either elderly carers or people with significant support

needs in terms of their mental health."4. This finding appears to be mirrored in this case. Issues in the sharing of key information were identified with stating they ASC received three PPNs and Police records state five were shared. Assessment and treatment Plans without a full picture of risk and issues concerning the safety of carers involved and that any liaison with the family was usually initiated by the family rather than the services involved.5

7.5 Edward's family were not alerted to the risks they were living with or advised that they themselves were the victims of domestic abuse including economic abuse and at risk by the professionals involved. Edward's mother, when asked by the Panel Chair directly, told the Chair that neither she nor Edward's brother recalled at any point contributing to a DASH risk assessment that had been completed following her call to the Police. Edward's mother was familiar with the DASH due to having been in a previous abusive relationship. Edward's father like many other victims of IFV and IFA felt that he was able to manage the perpetrator and minimised the threat posed by his son, for instance he declined added security as his son was at that point hospitalised. There is no evidence that attending officers discussed or tried in any way to challenge his belief in this. This is a common feature identified within the Standing Together review.[6]

8 CONCLUSIONS

8.1 The lesson from this enquiry is that Services in Southampton find it difficult to identify and respond to Intimate Family Violence (IFV) or Abuse (IFA). This is made worse by family members that live with Intimate Family Violence or Abuse themselves not being able to identify it, even when they have been previous victims of Intimate Partner Violence. All services, apart from the Police treated the family exclusively as carers and not victims.

8.2 The Police response did identify the family as victims and offered target hardening to Edward's father's property in response to an incident of IFV. They also completed a DASH on two occasions and shared information appropriately. This did not secure the family's safety for several reasons. Firstly, the DASH only scored Medium risk on both occasions it was completed, and Peter did not want his information shared with specialist support agencies. Part of the explanation for this is the Panel believe, due to DASH not being designed for and therefore not accurate in identifying and predicting IFV as identified by the Standing Together research. Many of the scores are linked to a victim's perception of threat, fear, instances of abuse etc which, when a victim is not aware of being a victim of domestic abuse will score low and the evidence that victims in these cases may minimise their level of risk. The

[4] Standing Together: DHR Case Analysis 2019 Executive Summary London Domestic Homicide Review (DHR) Case Analysis and Review of Local Authorities DHR Process Bear Monique October 2019

[5] Ibid

[6] Standing Together: DHR Case Analysis 2019 page 14 "Agencies should always refer to the MARAC based on professional judgement when information is limited, and the victim/survivor is perceived to be minimising the risks/is unable or too fearful to disclose the full extent of the abuse"

other issue may be how the DASH was approached in the two occasions it was used. Edward's mother when asked about the DASH said that she had never been spoken to on her own, nor as far as she knew had a DASH been completed on her. Hampshire Constabulary require that Officers do not take a tick box approach with victims when assessing risk, endeavouring to complete it in a conversation as opposed to completing a form. However, it appears from the family's recollection that they did not tell Edward's mother or brother that this was a domestic abuse incident, both presented as intelligent and able individuals who assured the review that this was never indicated by any agency and that if they had been told they would have informed themselves of what this meant in terms of protecting themselves and Edward. Finally, Hampshire Constabulary must be commended for their sensitive and considered approach to managing Edward. They were always focussed on his safety and well-being.

8.3 Solent and Southern NHS Services were also unable to identify the family members as victims in the Panel's view. In none of the records is there any recognition of the risk posed by Edward to his family or members of the public even though he had assaulted a Healthcare worker. This has been identified by the Standing Together as a national problem. The Domestic Homicide Project Spotlight Briefing #1: Adult Family Homicides published in January 2022 by the Vulnerability Knowledge and Practice Programme (VKPP)[7], which was established by National Police Chiefs' Council and the College of Policing identifies these issues as a common theme and therefore should be responded to systemically. There also appears to be an issue which this case has revealed of information sharing within NHS services in Southampton. A disclosure was made to EIP of Edward having delusional thoughts about his father and his girlfriend and filming family members to evidence his fears, making threats to kill his father, and possibly presenting a danger to his girlfriend during a meeting in a café in Southampton in early January 2020. There is no evidence of this information being passed on to the Police or Solent NHS Trust. We do not know if had it been it would have prevented the tragedy but clearly is an issue to address.

8.4 Finally Adult Services had no role in this case, although they were forwarded information by the Police and so were aware of it. The system of information sharing appears to be unreliable.

9 LESSONS TO BE LEARNT

1. That communication between the agencies involved in this case was sporadic, The Panel view was this would have been improved by the triggering of a MARM meeting by any of the agencies involved.
2. Issues in the sharing of key information were identified with stating they ASC received three PPNs and Police records state five were shared.
3. The Panel have learned there are wider issues related to the MARM process.

[7] /Research/AFH%20Spotlight%20Briefing_FINAL.pdf

4. Had domestic abuse been assessed effectively on all occasions it is highly likely a referral to HRDA would have been made.
5. That it is difficult for Services to Identify and respond to IFV and IFA
6. The victim's role as a carer was not recognised by agencies dealing with him.
7. That the focus of all agencies involved in this case was away from those with close relationships with the perpetrator and directed only on him
8. That the assessment and management of risk of harm such as the corelation with assaults on staff is not well developed within key agencies.
9. The family were not helped or provided with advice to manage the risks posed by Edward and so remained unaware of their vulnerability.
10. Edward's relationship over the previous year with his girlfriend was not visible to any agency involved with Edward, yet she was potentially at risk.
11. There was a confusing number of teams and professionals involved in the management of Edward's mental health. This made it difficult for his family to access help, advice, and support. There was no single Point of contact.
12. No agency signposted to DA services presumably because they did not identify it as such or because consent was not given.
13. The management of 'threats to kill' varies according to agencies, with Hampshire Police using a systematic approach which analyses risk in terms of the 'Real and Immediate' nature that other agencies could learn from. Housing has a Priority Index Tool which is an aid to staff assessing risk with threats of this nature.
14. Some practice was evident that was potentially dangerous- for instance EIP staff suggesting a joint family meeting in response to the disclosure of Edward making threats to kill a family member.
15. Managing the issue of deterioration in Edward's case by Mental Health workers did not include safety plans for family.
16. The physical and emotional impact these events have had on the family. Edward's mother describes 'living on pins for six years.
17. The issue of 'capacity' in Hampshire Constabulary charging decisions had the potential to cause confusion. This has been resolved by Operation Cavell.
18. The threats to steal money, steal money and damage property were not seen by agencies as economic domestic abuse.

10 RECOMMENDATIONS FROM THE REVIEW

10.1 Advice to be sought from the Home Office on the effectiveness of DASH as a risk checklist in cases where an adult child poses a threat to a parent.

10.2 That Southampton Local Authority harnesses the powerful messages expressed by this family concerning the impact the tragedy has had on them and their hopes for how families like theirs might be better helped in the future by working with them to produce a short video to be used by all agencies in their DA training for front line and associated workers.

10.3 That all agencies are explicit when risk assessing victims and family members about why an assessment is being undertaken and to be able to identify and evidence their assessment of the nature, level of seriousness and imminence of the risk they believe exists. If professionals believe victims to be minimising the risk posed by a family member, they should use their professional judgement to make HRDA referral in line with learning from the Standing Together research.

10.4 That Southern Health NHS Foundation Trust review the format of its SI's to reflect the whole person and does not frame the individual purely by any negative, criminal, or anti-social behaviour or other discriminatory identifiers.

10.5 That Southern Health NHS Foundation Trust review its 'Carers Strategy' to ensure that initial Psychiatric assessments are shared and communicated with the wider family where possible while working with and in event of serious events involving their family or the patient/client. This is in line with recent findings in the Domestic Homicide Project Spotlight Briefing #1: Adult Family Homicides Research January 2022 referred to earlier in this Review. Additionally, that in this, and in all future such cases to allocate an identified SPOC so that the family members can be communicated with sensitively and compassionately and to reduce re-traumatisation due to having to repeat their circumstances and background each time they speak to a member of staff.

10.6 That Southern Health NHS Foundation Trust ensure a distressed caller receives a follow up call or if not operationally possible a signposting to an appropriate agency at the time and that they secure a separate and confirmed assurance that the distressed caller has support from family or friends.

10.7 Commissioners of services to require as a condition of contract an assurance that such services offered are fit for purpose for this group of service users with mental health needs. And that the additional vulnerabilities of both client and carers and linked risks of domestic abuse are recognised and factored into any contract agreement, with a protocol (or agreed terms in the contract) in place to ensure service providers accept and respond to their duty to help to protect potential victims.

10.8 All Health organisations Domestic Abuse Policies need to be embedded in practice and relate to staff as well as patients. This must go beyond intimate partner abuse, which is generally recognised but also to include intra familial violence, which as research and this specific case shows is not so well recognised or even known of. DA 'complexities' training should be mandatory for all grades of staff, and it should follow the 'NICE' guidelines. All frontline staff should be expected to sensitively enquire about DA, including the identification of potential perpetrators and any risks they may pose to carers and/or other family members. If risks have been identified, safety planning must follow. Information sharing within an integrated care pathway should support this. This should be a standard item in both clinical and safeguarding supervision.

10.9 The Southampton Safer City Partnership Board and SSAB in light of this case review agency cohesion and joint working in the Southampton area. The Review heard of a complex landscape of agencies and Health bodies with often difficult and fractured lines of communication, a commitment should be made to undertake regular multi agency audits of cases. This to be a shared venture with representatives from all relevant agencies participating and sharing information and recommendations from the learning. The learning from these audits to be shared with all relevant staff and stakeholders.

10.10 That all agencies in Southampton to have an action Plan in place to prepare for the introduction and need to implement the Domestic Abuse Act 2021. That this action plan includes a policy and process on the risk assessment and management of domestic abuse. This is a wide-ranging act which will have consequences for many agencies both within and outside of the DA sector. This will include many new duties to collect, store and share information and will require modification to current rules and methods of information storing and sharing.

10.11 This recommendation builds on the Southampton wide Carers Strategy which has been developed in an ongoing partnership with carers and whose governance sits with the Better Care Board (under the Health and Wellbeing Board).

I. The Better Care Board (Health and Wellbeing Board) is assured that the staff (paid or unpaid) across the city are able to identify carers and know how to respond to their safety, wellbeing, and support needs, including sharing information with relevant services where this is needed.

II. That the Southampton wide Carers Strategy includes an emphasis on carers and safeguarding, a focus on both the carer and the adult they care for, including why carers may be at risk of harm and what may prevent, reduce, or stop the risk. The learning within the recent Carers and safeguarding: a briefing for people who work with carers | Local Government Association would support this.

III. To support the effective safeguarding of carers the strategy should also include a link to guidance for frontline workers in speaking privately with carers, using an agreed list of questions that cover issues of coping, fear, threat, and safety to ensure proper assessment and response to any identified areas of concern.

IV. The 4LSAB Family Approach is due for revision and should be relaunched with a focus on identifying risk and needs of carers as well as adults with care and support needs. This includes an expectation of using the Multi Agency Risk Management framework and any other multi-agency forums for the management of any risks to carers/family members from the adult with care and support needs.

10.12 Southern Health Foundation Trust agree the safeguarding pathway they are currently (as of June 2022) reviewing. This will provide a streamlined procedure for responding to safeguarding concerns. Including finalising the safeguarding module

on the Rio recording system which will enable them to record safeguarding concerns if the Section 42 threshold has been met and the outcome of the safeguarding concern.

10.13 That all front facing workers and managers receive training that enables them to identify risks posed to family and carers in non-intimate familial relationships and ensure all workers understand and appropriately assess the impact of known risk factors such as substance abuse and poor mental health which may increase risk to family members. The Panel accept that this is a long-term project which will involve a cultural shift in how workers see and approach their work with the client/patient. It is anticipated that achieving this shift will involve four steps; 1) Raising the awareness of workers to non-intimate familial violence/control, 2) sourcing or developing the training material and 3) Committing to, providing, and resourcing the training, and 4) Embedding and ensuring that the learning is being applied in practice through clinical supervision and evidence in casework files.

10.14 That the Authority request that the Home Office commission the development of a brief and user-friendly Domestic Abuse assessment tool that can be used for non-intimate partner and inter family violence and abuse with confidence.

10.15 That Southern Health NHS Foundation Trust will seek to move recording of events and the presentation of service users from one which is primarily clinical, and evidence based to one that also includes an assessment of that evidence.

10.16 That all GP's in the area are aware of and subscribe to the good practice identified in the Royal College of General Practice 2013 Policy document "Supporting carers in general practice: a framework of quality markers".

10.17 The CCG promote a consistent approach with Carers across the GP Surgeries they commission to include: -

- As a minimum all GP surgeries (if they do not already have in place) to develop a list of all patients who are also carers and to have a marker system so that such patients are identified automatically to both GP, reception and any other auxiliary nursing staff linked to the practice.
- To encourage all GPs in the area to develop a process to actively identify, refer, and support carers including children and young people, to reduce or prevent inappropriate caring responsibilities, because of taking on caring roles.
- To ensure all GP's provide written advice to carers, including young carers, of their right to request a carer's needs assessment.
- To ensure carers are encouraged to book a separate appointment for themselves to discuss what matters to them, including their own health and wellbeing needs.

10.18 The SSAB and Southampton Safe City Partnership share all agencies assessment and management tools for when ‘Threats to Kill’ are made with a view to learning from each other and establishing what is best practice.