GLOUCESTER CITY COMMUNITY SAFETY PARTNERSHIP AND SAFER GLOUCESTERSHIRE DOMESTIC HOMICIDE REVIEW

Overview Report into the unlawful killing of a 35-year-old man in January 2019

Independent Chair and Author of Report: Paula Harding

Associate of Standing Together Against Domestic Violence

June 2020

Abbreviations

AAFDA: Advocacy After Fatal Domestic Abuse

CSP: Community Safety Partnership

CCG: Clinical Commissioning Group

CCR: Co-ordinated Community Response Model

CGL: Change, Grow, Live

CPS: Crown Prosecution Service

DASH: Domestic Abuse, Stalking and Harassment risk assessment model

DASV: Domestic Abuse and Sexual Violence

DoH: Department of Health

DHR: Domestic Homicide Review

DVA: domestic violence and abuse

GDASS: Gloucestershire Domestic Abuse Support Services

GP: General Practitioner

IMR: Individual Management Review

IRIS: Identification and Referral to Improve Safety

MASH: Multi-Agency Safeguarding Hub

NIHR: National Institute for Health Research

STADV: Standing Together Against Domestic Violence

VIST: Vulnerability Identification Screening Tool used by Gloucestershire Constabulary

Glossary

Body warn camera: a video camera, worn on the helmet or upper body of an officer, which records visual and audio footage of an incident

CS Spray: 2-chlorobenzylidene malononitrole gas used as a temporary incapacitant by UK police forces

Identification and Referral to Improve Safety: a general practice-based domestic violence and abuse training support and referral programme

Individual Management Review: reports submitted to the review by agencies

The **Quality and Outcomes Framework (QOF)** is a voluntary annual reward and incentive programme for all GP surgeries in England, detailing practice achievement results. It is not about performance management but resourcing and then rewarding good practice

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Preface

Members of the review panel offer their deepest sympathy to the family and to all who have been affected by the death of the homicide victim and that of his mother.

The Chair would like to thank the panel and contributors for their commitment to the review and to improving services for victims of domestic abuse.

The homicide victim's siblings and wider family have kindly offered the following statement to support the review.

> *"As a family our lives have changed forever. [The homicide victim] and [his mother] will forever be in our hearts, we miss them both greatly. We know that [the homicide victim's mother] loved all of her children dearly, that she was full of remorse for her actions on that day and that she could not live with her pain. We also know that [the homicide victim] loved both of his parents. Unfortunately, the events that happened on that fateful day will be a heart-breaking reminder to us of the tragic effects of alcohol abuse.*
>
> *We hope that the review will help to improve working practices and increase awareness for the services available for people, so that other families do not have to share our pain."*

1. Introduction

1.1 Background

1.1.1. This review concerns the death of a thirty-five-year-old man who died as a result of unlawful killing. His mother was charged with his murder but herself died some months later before the prosecution was concluded.

1.1.2. The homicide victim had lived with his mother and father throughout his life but his relationship with them was understood to have been strained and five reports of disorder or his domestic abuse towards his parents had been made in recent years. The panel therefore considered within this review what might have been known about domestic abuse in the household as a whole.

1.2 Aim and Purpose of a domestic homicide review

1.2.1 Domestic Homicide Reviews (DHR) came into force on the 13th April 2011. They were established on a statutory basis under Section 9 of the Domestic Violence, Crime and Victims Act (2004). The Act states that a DHR should be a review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by (a) a person to whom she was related or with whom she was or had been in an intimate personal relationship or (b) member of the same household as herself; with a view to identifying the lessons to be learnt from the death.

1.2.2 The purpose of a DHR is to:

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

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

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

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

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

f) highlight good practice" (Multi-Agency Statutory Guidance 2016, para 7)

1.2.3 As well as examining agency responses, statutory guidance requires reviews to be professionally curious and find the "trail of abuse". The narrative of each review should "articulate the life through the eyes of the victim…The key is situating the review in the home, family and community of the victim and exploring everything with an open mind". (*Multi-Agency Statutory Guidance 2016, paras 8 and 9*).

1.2.4 Hence, the key purpose for undertaking a domestic homicide review is to enable lessons to be learned where a person is killed as a result of domestic violence, abuse or neglect. In order for these lessons to be learned as widely and thoroughly as possible, professionals need to be able to understand fully what happened in each homicide, and most importantly, what needs to change in order to reduce the risk of such tragedies happening in the future.

1.3. Timescales

1.3.1. Gloucester City Community Safety Partnership were notified of the death by Gloucestershire Constabulary in February 2019. The decision to undertake a review was made by the Chair of the Partnership after consultation with Safer Gloucestershire and the Home Office was notified in March 2019[1].

1.3.2. Commencing in June 2019, the panel met three times during which, panel members were able to discuss the progress of the review and request further clarification and additional material, where needed. All panel meetings were minuted and all actions agreed for the panel have been tracked and signed off.

1.3.3. The panel considered and agreed the draft Overview Report in June 2020, following a significant submission by the wider family. The finalisation of the review had been delayed as a result of arrangements to address the Covid-19 pandemic. The final Overview Report was endorsed by the Community Safety Partnership in August 2020 (virtually[2]), prior to submission to the Home Office.

1.4. Confidentiality

1.4.1 This Overview Report has been anonymised in accordance with statutory guidance. The family preferred not to use pseudonyms and individuals have therefore been referred to in the report by their relationship to the homicide victim.

1.4.2 Whilst the details of each review remain confidential, available only to participating professionals and their direct line management, the report has sought to extract sufficient detail from the family's narrative for the lessons

[1] Precise dates redacted.
[2] Sign off was achieved virtually due to workplace and meeting restrictions as a result of Covid-19

and recommendations to be understood, whilst balancing this need for confidentiality.

2. Terms of Reference

2.1. Methodology

2.1.1. The review followed the methodology required by the statutory guidance. All local agencies were notified of the death and were asked to examine their records to establish if they had provided any services to the family and to secure records if there had been any involvement.

2.1.2. Arrangements were made to appoint an Independent Domestic Homicide Review Chair and Author and agree on the make-up of the multi-agency review panel.

2.1.3. As a result of the death of the homicide victim's mother, criminal investigations did not conclude at the criminal court. However, the police Case Manager and Family Liaison Officer from the criminal investigation attended the first panel meeting and were able to provide their findings and details of the family who were to be invited to engage with the review.

2.1.4. The terms of reference for the review were drawn up by the Independent Chair together with the panel incorporating key lines of enquiry and specific questions for individual agencies. Chronologies and Individual Management Reviews (IMRs) were requested to be undertaken as well as information reports from agencies with less involvement.

2.2. Involvement of Family and Friends

2.2.1. Family members were notified about the domestic homicide review through letters from the Chair, delivered by the police Family Liaison Officers, alongside leaflets from the Home Office and specialist support services, namely Advocacy After Fatal Domestic Abuse (AAFDA) and the Victim Support Homicide Service. The Family Liaison Officers discussed the aims and purpose of the review with the family and advised how they could be involved. Whilst the family declined to participate in the review earlier, they welcomed the chance to receive the draft report. They met with the Chair[3], who introduced the findings of the review, and they were given the opportunity to comment thereafter. Their comments, which have been incorporated into the report, provided a significant insight into the lives of their family members and the challenges they faced.

2.2.2. The Chair wrote to the homicide victim's neighbours and friends, where known, again providing Home Office leaflets and details of support services and was able to engage with neighbours who provided helpful context and detail, which has been incorporated into the review.

2.3. Independent Chair and Overview Author

2.3.1 The Independent Chair and Author is Paula Harding, an Associate Chair with the charity, Standing Together Against Domestic Violence. She has over twenty-five years' experience of working in domestic abuse with both senior local authority management and specialist domestic abuse sector experience. For more than ten of those years she was a local authority strategic and commissioning lead for domestic abuse and violence against women and has been an independent chair and author of domestic

[3] The meeting was held by video-conference as the review concluded during the Covid-19 restrictions on movement and meeting in March 2020.

homicide and safeguarding adult reviews since 2016. She completed an M.A. (Birmingham) in Equalities and Social Policy in 1997, focusing on domestic abuse and social welfare, and is a regular contributor to conferences, national consultations and academic research. She completed the OCR certificated training funded by the Home Office for *Independent Chairs of Domestic Homicide Reviews* in 2013. She has also completed the on-line training provided by the Home Office,[4] as well as undertaken accredited training on the Significant Incident Learning Process and Learning Disability Mortality Reviews.

2.3.2 The review was managed and administered by Standing Together Against Domestic Violence which is a UK charity bringing communities together to end domestic abuse. It promotes the adoption of the Coordinated Community Response (CCR) Model across the country. This model is based upon the principle that no single agency or professional has a complete picture of the life of a domestic abuse survivor, but many will have insights that are crucial to their safety. It is paramount that agencies work together effectively and systematically to increase survivors' safety, hold perpetrators to account and ultimately prevent domestic homicides. STADV has been involved in the domestic homicide review process since its inception, chairing over sixty reviews to date and bringing expertise and support to the Independent Chair and the review.

2.3.3 Beyond this review, the Chair has no connection with Gloucester City Community Safety Partnership or any of the agencies involved in this case.

[4] Available at https://www.gov.uk/guidance/conducting-a-domestic-homicide-review-online-learning

2.4. Members of the Review Panel

2.4.1 Multi-agency membership of this review panel consisted of senior managers and designated professionals from the key statutory agencies who were all independent of the case.

2.4.2 Wider matters of diversity and vulnerability were considered when agreeing on panel membership. Gloucestershire Domestic Abuse Support Service provided particular expertise on domestic abuse and the 'victim's perspective' to the panel. Change, Grow, Live (CGL) provided particular expertise on alcohol misuse which was an important feature of this review.

2.4.3 The review panel members were:

Name	Role and organisation
Paula Harding	Independent Chair of this review and Associate of Standing Together Against Domestic Violence
Faye Satchwell-Bennett	Detective Constable, Gloucestershire Constabulary
Heather Downer	Service Manager, Gloucestershire Domestic Abuse Support Service
Helen Pritchard	Domestic Abuse and Sexual Violence Co-ordinator, Gloucestershire Constabulary and Gloucester Council
Sophie Jarrett	Public Health Outcome Manager for Violence Prevention, Gloucestershire County Council[5]
Ian Tonner	Area Manager, Gloucestershire Fire and Rescue Service
Jeanette Welsh	Lead for Safeguarding Adults, Gloucestershire Hospitals NHS Foundation Trust
Katy McIntosh	Named GP for Safeguarding Adults and Children, NHS Gloucester Clinical Commissioning Group
Michelle Wheatley	Housing Team Leader, Gloucestershire City Council
Lisa Demain	Gloucestershire Services Manager, CGL (providing services for substance misuse locally)
Richard Ocone	Detective Chief Inspector and Domestic Abuse Lead, Gloucestershire Constabulary

[5] Sophie Jarrett was seconded from the role of Domestic Abuse and Sexual Violence Co-ordinator during the review but continued to be a panel member in order to maintain consistency in the process

Steve O'Neill	Public Health Outcome Manager Drug and Alcohol, Gloucestershire County Council

2.5. Time period

2.5.1. The panel agreed that the review should focus on the contact that agencies had with the homicide victim and his mother during the period January 2011, in order to cover the period involving a house fire at the family home, until the victim was killed in January 2019. Agency involvement prior to 2011 was summarised by key agencies, particularly in relation to the homicide victim being arrested for the assault of his mother in 2007.

2.6. Key Lines of Enquiry

2.6.1. The review sought to address both the 'circumstances of a 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 the opportunity for agencies to safely and routinely enquire, identify, assess and respond to domestic abuse and the threat and needs arising. This should include whether the opportunity was made to speak with either party on their own.

- Analyse how the homicide victim's alcohol use was understood in relation to his care needs and risk to himself and others.

- Analyse how organisations sought to enable engagement with specialist domestic abuse or substance misuse agencies for either party.

- Analyse the effectiveness of multi-agency working, including information sharing and expectations of other agencies when information was shared.

- Assess the policies, procedures, supervision, support and training available to the agencies involved on domestic abuse issues, including familial abuse.

2.6.2. Individual agencies were asked to respond to further key lines of enquiry.

- Gloucestershire Constabulary to provide a summary assessment of relevant incidents prior to 2011, with particular regard to an incident of assault in 2007.

- Gloucestershire Hospital NHS Foundation Trust to also specifically consider how the victim's multiple attendances and subsequent non-attendances for follow-up appointments were responded to.

- The Clinical Commissioning Group to:

    - Assess what opportunities there were for the GP Practice to make routine enquiries of the homicide victim's mother into domestic abuse and what was expected practice at the time.

    - Assess what opportunities there were for the GP Practice to make routine enquiries of the homicide victim's mother regarding her alcohol consumption and assess the GP Practice's response.

    - Assess what opportunities there were to respond to the frequent notifications about the homicide victim's attendances at Emergency Departments and non-attendance at follow-up appointments and whether alcohol was known to be a feature.

- Gloucestershire Fire and Rescue Service to:

- Provide a summary of findings regarding a house fire in 2011.

- Assess the preventative actions that were taken thereafter, particularly in respect of alcohol use.

- Gloucestershire Domestic Abuse Support Service to provide a summary of their domestic abuse, including familial abuse, initiatives in primary and acute health settings and plans for the future.

- Gloucestershire Domestic and Sexual Violence Co-ordination to provide a summary of local initiatives to raise public awareness of domestic abuse, including familial abuse.

2.7. Individual Management Review Reports (IMRs)

2.7.1. An IMR and comprehensive chronology was requested from the following organisations:

- Gloucestershire Constabulary
- Gloucestershire Hospital NHS Foundation Trust

2.7.2. The following agencies with briefer involvement were asked to complete Chronologies and Information Reports:

- Gloucestershire Clinical Commissioning Group
- South Western Ambulance Service Trust
- Gloucestershire Fire and Rescue Service

2.7.3. The following agencies provided summaries of specific interventions in their area, as detailed above:

- Gloucestershire Domestic Abuse Support Service
- Gloucestershire Domestic and Sexual Violence Co-ordination

2.7.4. IMRs were authored by professionals who had not had any direct contact or management involvement with the homicide victim or his family. All agencies

were asked to identify good practice as well as to address issues of immediate concern whilst the review progressed.

2.8. Agencies without contact

2.8.1. The following agencies were contacted but confirmed that the family members had not been known to them:

- Change, Grow, Live (CGL) (substance misuse services)
- Gloucester Care Services NHS Trust (community health services)
- Gloucestershire County Council Adult Services
- Gloucestershire County Council Children's Services
- Gloucester City Council Housing Services
- Gloucestershire Domestic Abuse Support Service (GDASS)
- National Probation Service
- Working Links Community Rehabilitation Company
- Victim Support
- 2gether NHS Foundation Trust (mental and social health care services)

2.9. The definition of domestic violence

2.9.1. The Government's definition of domestic violence, which sets the standard for agencies nationally was applied to this review:

"Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass but is not limited to the following types of abuse: psychological, physical, sexual, *financial*, *emotional.*

Controlling behaviour is a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of

the means needed for independence, resistance and escape and regulating their everyday behaviour.

Coercive behaviour is: an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim" (HM Government, 2013).

2.9.2. At the time of writing, the Domestic Abuse Bill 2020 has been making its passage through parliament and, if enacted, will provide a legal definition of domestic abuse and one which incorporates economic abuse, which is particularly relevant to this case. Whist yet to be defined in law, economic abuse is understood to include, "behaviours that interfere with the ability to acquire, use and maintain economic resources" (Sharp-Jeffs, 2017:6).

2.10. Parallel Reviews

2.10.1. Beyond criminal proceedings, the review panel was not made aware of any parallel proceedings. However, the causes of death of both the homicide victim and his mother were determined by the inquest. The homicide victim was found to have been unlawfully killed and his mother later died of natural causes.

2.11. Equality and Diversity

2.11.1. The review gave due consideration to the homicide victim's vulnerabilities alongside each of the nine protected characteristics under Section 149 of the Equality Act 2010.

2.11.2. The homicide victim was a white British, heterosexual male, aged thirty-five when he was killed. He worked seasonally as a gardener but otherwise had no independent income, experienced increasingly problematic alcohol use and it was suggested by his father that he may have had an undiagnosed

learning disability,[6] although other family members did not agree. It was also considered that the homicide victim may have had an acquired brain injury following an assault. In this way, the protected characteristics of sex, disability and vulnerabilities of alcohol and economic dependency were considered pertinent to this review in respect of the homicide victim.

2.11.3. Both of his parents had retired, and his mother was aged 65 at the time of his homicide. Both parents were also of white, British ethnicity. Whilst no religious or cultural factors were made known to the review concerning the family, the older ages of the parents, where 'older' in this instance refers to those aged 65 and over, were considered.

2.11.4. In terms of additional vulnerabilities, all members of the family experienced problematic alcohol use for the period in question and so the vulnerability of alcohol dependency was considered.

2.11.5. The panel agreed that it was important to have an intersectional framework to review the family's life experiences. This means to think of each characteristic of an individual as inextricably linked with all of the other characteristics in order to fully understand an individual's journey and experiences with local services and within their community. These considerations feature within the body of the report which follows.

2.12. Dissemination

2.12.1. The following organisations will receive copies of this review

- The bereaved family
- Gloucester City Community Safety Partnership and its agencies
- Gloucestershire Police and Crime Commissioner

[6] This report follows the guidance provided by NICE (2015) in respect of the use of the terminology for (non-specific) learning disability. Whilst the term 'intellectual disability' is becoming accepted internationally, 'learning disability' is the most widely used and accepted term in the UK and is therefore used here.

- Gloucestershire Safeguarding Adult Board
- All agencies involved in the review and beyond through publication on the Gloucester City Community Safety Partnership website
- Department of Health and Social Care

3. Background Information

3.1. Persons involved in this review

3.1.1. In order to protect the identity of the homicide victim, family and significant others, the following anonymised terms have been used throughout this report:

Designation	*Relationship*	*Age at the time of the death*	*Residing with victim at the time of his death*
The homicide victim	The victim	35	-
The homicide victim's mother	Mother of the victim and person responsible for his unlawful killing	65	Yes
The homicide victim's father	Father of the victim	Not relevant	Yes

3.1.2. The homicide victim had two older brothers and a sister who also lived in the Gloucestershire area. He was far younger than his siblings who had left home whilst he was young. Family members described how his parents had been alcoholics since his childhood and that alcohol had been a constant feature in his life. They described how he had grown up lacking confidence and experienced extreme anxiety in social situations unless he had consumed alcohol which made him more confident and able to go out to pubs at night.

3.1.3. As an adult, he worked seasonally as a landscape gardener: working on his own and being paid "cash-in-hand". Instead of claiming welfare benefits when not working, he was financially dependent upon his parents. Family members considered that he would not have been able to claim benefits as he would not have understood how to complete the forms, could not talk on the phone and had severe social anxiety.

3.1.4. Despite their problematic alcohol use, the homicide victim's parents had both continued to work locally in manual professions and his mother had recently retired. His parents had always cycled to work daily and were described as very independent and private people.

3.1.5. In terms of the family dynamics, the review heard how the homicide victim continued to live with his parents into adulthood and how, whilst the parents appeared to clearly love their son, emotional support had rarely been displayed. His father told a neighbour that he thought his son may have had a learning disability. The homicide victim also suffered the first of two head injuries in 2008, following a serious assault, after which his behaviour was noted, by those close to him, to have deteriorated, although no acquired brain injury had been medically diagnosed.

3.1.6. Whilst problematic alcohol use had been a regular feature of family life, it was considered by wider family members that it was likely that retirement brought new pressures to the household. This may have accounted for the increased alcohol use thereafter.

3.1.7. The family were very private but enjoyed seeing their wider family. The homicide victim's sister and her three children regularly visited at weekends and over holiday periods. The nieces and nephews often played football with their uncle and enjoyed coming to the house which was described by the wider family as a fun place to be. No member of the family would drink alcohol if the children were visiting. Beyond contact with family and

neighbours, the family were described as content to stay at home and did not go away on holiday. The homicide victim's contact with others mainly revolved around regular visits to the city's pubs.

3.2. The homicide

3.2.1. Just after midday on the day of the homicide in January 2019, the homicide victim's father called 999 stating that his wife had stabbed his son. An ambulance pronounced the victim dead at the scene.

3.2.2. Both the homicide victim and his mother were found to be intoxicated[7] at the time of the homicide. On the night before the homicide, the family had all been drinking. The homicide victim's parents were in their bedroom with the door locked but the homicide victim forced his way into their room, breaking the lock. He grabbed his father by the throat and stole cigarettes from the bedside cupboard. It transpired that his parents had put locks on their bedroom door which family members thought was specifically to stop their son taking cigarettes and alcohol from them.

3.2.3. Early on the morning of the homicide, the homicide victim's mother gave him some money which he used to buy cigarettes and alcohol. He went to the shop three times that morning and purchased a total of three bottles of vodka during these trips. All three members of the family went on to consume alcohol. Thereafter, the homicide victim's father heard his wife upstairs asking their son to leave her alone and the homicide victim came downstairs, telling his father that his mother had stabbed him and collapsed on the floor. His father contacted 999 and attempted CPR.

3.2.4. The homicide victim's mother was arrested then charged with murder and bailed by the court to stay at her home address. However, her husband suffered a stroke and the homicide victim's mother broke the conditions of

[7] Intoxicated at a level two and half times over the drink-driving limit

her bail by leaving the family home and escorting her husband to hospital. She was arrested again and remanded back to prison. The homicide team arranged for her release and she returned home but died of natural causes before her trial commenced. The inquest concluded that the homicide victim had died from a single stab wound to the chest and been unlawfully killed by his mother.

4. Chronology

4.1 The sections below have been based on information provided from agencies' reports, family and neighbours; summaries of criminal proceedings and the outcome of the inquests into the two deaths. They represent the independent author and review panel's view of significant information and events about the homicide victim and his mother.

4.2 In October 2007, the homicide victim was admitted to Gloucestershire Royal Hospital having fractured his ankle whilst intoxicated.

4.3 During the Christmas of that year, the homicide victim's mother called the police stating that her son was drunk and wrecking the house. She also stated that her son assaulted her every week. When the police arrived, she went on to say that her son had pushed her and that she wanted to press charges. As a result, the homicide victim was arrested for common assault and taken to custody. Thereafter, his mother declined to make a complaint, denied making the allegation and the homicide victim was released without charge or interview. An assessment of risk[8] was undertaken and standard risk was recorded on the domestic abuse database which was in operation

[8] This was prior to the introduction of the Domestic Abuse Stalking and Harassment (DASH) model of assessing risk that was introduced in 2009 in Gloucestershire.

at the time. It was recorded that the case did not meet the threshold for further referrals.

4.4 Two days later, the police were called to the family home again as a result of a verbal argument between the homicide victim and his parents, all of whom were found to be intoxicated. It was revealed to police officers that the arguments centred around the homicide victim not working and living with them rent free. No offences were disclosed but a risk assessment was completed and assessed as standard risk.

4.5 After these two incidents, the police did not receive another domestic abuse related report for nine years. However, the homicide victim was known to the police before and after these incidents for alcohol related disorder in the pubs and clubs in the area. By 2011, he had received: two cautions; a pub-watch warning letter; experienced the deployment of CS spray; been charged for being drunk and disorderly and given a temporary ban from the city centre[9].

4.6 In February 2011, the homicide victim's mother attended the Emergency Department at Gloucester Royal Hospital with a probable fracture of her wrist which was put into a splint. She advised that she had fallen off her bike and the injury was consistent with this explanation as the homicide victim's mother cycled to and from her place of work each day.

4.7 The following day, Gloucestershire Fire and Rescue Service were called to a fire at the family home. The fire was found to have started in the kitchen as a result of a chip pan catching alight whilst unattended and it was noted that alcohol was a feature for the residents involved in the fire. Firefighters

[99] The 24 hour ban from entering Gloucester was made as a S27 Notice under the Violent Crime Reduction Act 2006)

assisted the homicide victim to exit the home and all parties were reported to have been overcome by smoke fumes.

4.8 The homicide victim and his parents were taken to the Emergency Department where the homicide victim advised staff that he had fallen asleep before the fire started and had drunk a litre of vodka that evening. He said that he lived with his father only and was noted to be offensive and obstructive during the examination.

4.9 Both the homicide victim and his mother self-discharged before they had been fully assessed. However, the homicide victim's mother self-discharged in order, it appears, to attend her appointment with the Fracture Clinic that had been made the day before, in the same hospital. At that time the Fracture Clinic would not have been able to see the notes from the Emergency Department from which to prompt further enquiry around the fire.

4.10 The homicide victim had burns to his feet but had declined any cleaning or dressing of the burns and self-discharged. However, he returned to hospital within the week with breathing difficulties but, after examination, was discharged to his GP without concerns. Thereafter, the family were thought to have re-located from their home for up to a year whilst repairs were done to the house to deal with the fire damage. As the local authority was not involved in assisting with this emergency, it was presumed that the family's house insurance enabled them to live temporarily elsewhere.

4.11 The house was refurbished to a high standard and neighbours commented on how the family were keen to move back in. Prior to the fire, the house had been described as being in a state of disorder as the homicide victim had damaged much of his belongings.

4.12 In April 2013, the homicide victim was a victim of a serious assault on his way home. He advised the Emergency Department that he been assaulted again whilst out in town drinking and suffered a head injury after being hit with a metal wrench. Police officers attended with him, but he was reluctant to discuss the episode and would not support a prosecution. Medical staff wanted to admit him overnight for observation, but he wanted to discharge himself. A mental capacity assessment was undertaken and his capacity to make decisions was documented as part of his self-discharge documentation. He failed to attend subsequent outpatient appointments at the maxillo-facial (jaws and face) trauma clinic and was discharged back to his GP. Family members reflected that his social anxiety would likely have prevented him from attending these appointments.

4.13 In March 2016, the homicide victim's father contacted the police, describing how his son was smashing things up and "going mental". Sounds of disorder and swearing could be heard in the background of the call and the police found both parties intoxicated when they arrived. It transpired that the homicide victim had smashed his television and arguments centred around his drinking, not moving out and relying upon his parents for money.

4.14 No offences had been disclosed as the homicide victim was found to have damaged his own belongings. However, an assessment of risk was made, using the Vulnerability Identification Screening Tool (VIST), and the level of risk was considered to be standard as there had been no threat of violence. The VIST was detailed and identified the financial and alcohol issues. However, no referrals appear to have made for alcohol treatment services nor consideration that the financial issues may have been indicators of economic abuse. Words of advice were given to the homicide victim who was removed from the property. He was reported to have calmed down and was taken to his sister's house where she told officers that she was happy to have him there.

4.15 Later that year, in October 2016, the homicide victim's father contacted the police again, saying that his son was "going mad" as a result of his alcohol intoxication. When the police arrived, they found all parties to be heavily intoxicated and the homicide victim left to go to his sister's house. Police records indicated that a decision was made not to complete a VIST as no offence had been committed and it was viewed solely as a verbal argument. No consideration appears to have been given to the history of callouts to this address, albeit irregular, or referrals to other services for support for the family.

4.16 In October 2017, the homicide victim's mother attended the Emergency Department having accidentally caught her thumb on welding equipment at work. Her injury was consistent with her explanation. She attended the Emergency Department again the following month with a swollen knuckle in another work-related injury. This was her last attendance at the Emergency Department.

4.17 In April 2018, the homicide victim was assaulted and knocked unconscious after having been ejected from a local pub for his intoxicated behaviour. He was taken to hospital by ambulance and was found to have suffered a fractured skull. Although he was kept in hospital overnight for observation, the fracture did not require further treatment. He was discharged the following day with written instructions to return if he experienced any adverse symptoms and with an appointment for a formal hearing test the next week as his hearing had been noted to be poor after the head injury. He attended the hearing test which had mixed results and was advised if there was no improvement within two months then he should return. He was not seen at Gloucestershire Hospitals again after this appointment. However, he told his family that he was not able to hear again in one ear after this injury.

4.18 In June 2018, the homicide victim was arrested outside a nightclub for assaulting door staff, whilst intoxicated. He was released without charge.

4.19 Three months before the homicide, in October 2018, the homicide victim's father contacted the police again reporting his son having returned home under the influence of alcohol and his behaviour being problematic whilst his grandchildren were present. However, the homicide victim had left before the police arrived and no further action, or VIST, was taken by the police.

4.20 The family had no further contact with agencies before the homicide.

5. Overview

5.0.1. This section considers the Individual Management Reviews (IMRs) and Information Reports completed by the individual agencies and the panel's contribution to their analysis.

5.1 Gloucestershire Constabulary

5.1.1. Gloucestershire Constabulary were asked to provide information on their involvement spanning twelve years prior to the homicide. This request was made in order to understand the family history rather than for the review to assess historic practice without the context of policy and procedures relevant at the time. Indeed, much will have changed in the police's policy and practice and multi-agency response to domestic abuse and to alcohol related offences in the intervening years. That said, the Constabulary have identified a number of shortcomings within their responses.

5.1.2. They considered that their first involvement with the family in December 2007 was a significant disclosure by the homicide victim's mother about

domestic abuse. Despite her initial support for a prosecution, his mother later withdrew her support and there was no indication that any other evidence was collected at the time. Nor was the homicide victim himself interviewed and it was pointed out that this would be highly unlikely to happen today. Since this time, significant training on domestic abuse has been delivered across the Constabulary, in line with the requirements of the HMIC inspections of domestic abuse (2014, 2016). Most recently, this has focussed on the victim response to trauma and concentrated on guiding officers to make time and space for the victim to engage. In this way, opportunities for officers to speak with the victim when sober and less distressed would have been followed by interviews with the detainee before his release.

5.1.3. In respect of evidence gathering, the panel heard how locally, police response officers now systematically utilise body-warn cameras to collect evidence at the scene. Had they been routinely available in 2007, they could have captured the initial account that the homicide victim's mother gave to officers about her son's violence towards her. This, together with the recording of the 999 call and other evidence gathering could have enabled consideration, although evidentially weak, for an evidence-led prosecution which would not have been reliant upon a victim's statement.

5.1.4. Gloucestershire Constabulary has also changed the manner in which it assesses risk and vulnerability over these times. In 2007, the Constabulary used an earlier version of a domestic abuse risk assessment for assessing domestic abuse related risk. In 2015, the police introduced a broader Vulnerability Identification Screening Tool (VIST) which incorporates the Domestic Abuse Stalking and Harassment (DASH) as well as wider vulnerabilities and risks. In terms of process, a completed VIST is automatically sent to the Multi-Agency Safeguarding Hub (MASH) where it is reviewed, recorded on police systems and shared with partners where

necessary. Those cases involving domestic abuse are also triaged at a daily multi-agency meeting.

5.1.5. Whilst this is a robust multi-agency response to police reports of domestic abuse, it nonetheless relies upon the identification of domestic abuse or vulnerabilities, repeat calls for assistance and the completion of the VIST by the responding officers. In this case, a VIST was not completed in either October 2016 or October 2018 and the repeat calls for assistance, whilst infrequent, did not appear to be recognised. In order to secure their approach, Gloucestershire Constabulary have made a recommendation that, through the MASH/daily domestic abuse meetings, that they identify repeat, standard risk cases and escalate concerns particularly if drug, alcohol or mental health are believed to be contributing factors. In respect of the familial abuse and vulnerability aspects, since this incident, they have put in place an electronic system which means that the particular log cannot be closed until a supervisor confirms they have received and endorsed the VIST, providing further assurance within the system that vulnerability and familial abuse will not be overlooked.

5.1.6. It was clear that each domestic abuse incident was responded to swiftly and promptly. However, the Constabulary have recognised that this earliest report was not recorded as a crime when it should have been. Accurate recording of domestic abuse incidents, whether they result in a crime or not, is important in building up a history of abuse to support effective responses in the future. A recent inspection by Her Majesty's Inspectorate of Constabulary and Fire & Rescue Services (HMICFRS, 2019) also found that crime recording was inadequate locally, and Gloucestershire Constabulary was required to take steps to improve its crime recording. In response, it has recently been meeting the National Crime Recording Standard in ninety-six per cent of cases (November 2019).

5.1.7. In these ways, more advanced policing of domestic abuse in recent years could have impacted positively upon the police response, had they been available at the time.

5.1.8. It was noted that, on the occasions that the homicide victim was taken into custody for alcohol related offences, alcohol treatment services were not well embedded in the custody suites and opportunities were therefore missed to speak with him whilst in custody and encourage his engagement with treatment services. Since this time, Change, Grow, Live (CGL) has become more embedded within the custody suites and provide access to treatment, rehabilitation and a link to the court systems. In order to ensure that this approach continues to be embedded, Gloucestershire Constabulary have made a recommendation for themselves to continue to recognise and assist persons presented in custody with alcohol and substance abuse to try and reduce offending and rehabilitate them.

5.1.9. However, there were a number of occasions where there may have been opportunities to refer either to city centre violence reduction initiatives or to signpost the homicide victim or his family to alcohol treatment services outside of the custody setting. How agencies respond to problematic alcohol use in the community will be addressed from a multi-agency perspective later in this report.

5.2 Gloucestershire Fire and Rescue Service

5.2.1 The Fire and Rescue Service recognised that when they responded to the fire in the family home in 2011, their service was more of a reactive one and links between their service and alcohol treatment services were not formalised. Although they followed up the fire by delivering leaflets to local residents advising them that a fire had occurred and offering basic fire

safety advice, no home fire safety check was followed up with the family as the smoke alarms were all working. It had been recorded that alcohol was a feature in the fire and that all family were members had been taken directly to hospital but no follow up was undertaken with the family in respect of the alcohol related fire. However, their response satisfied the policy and practice that was in place at the time.

5.2.2 Since this time, the Service has invested more heavily in both safeguarding and prevention (Safer Gloucestershire, 2018). Fire crews have all been trained in safeguarding and the identification of vulnerabilities. Had this fire happened in more recent times, the Service advised the panel that their prevention team would, at minimum: have visited the family; undertaken a risk assessment and shared information with partner agencies to assist with any issues of concern. In particular, as alcohol is known to be a significant catalyst in house fires, the Service has established close working relationships with CGL and has developed a joint protocol with them for the referral of new clients, involving joint visits where this vulnerability is already known.

5.2.3 Further positive relationships have been developed with Gloucestershire Domestic Abuse Services through the local Sanctuary Scheme and through the routine 'safe and well checks' that the Fire and Rescue Service introduced in 2015. Gloucestershire Fire and Rescue Service chairs the Fire Development Sub-Group of Gloucestershire Safeguarding Adult Board, implementing local and national learning from fire related harms and is well integrated into local multi-agency safeguarding practices.

5.2.4 The panel recognised that Fire Services have a key role to play in the prevention of many types of harm including domestic abuse and alcohol related risks. Public trust means that they are invited into family's homes more readily than many other services and therefore have a privileged

position to identify and act upon concerns within the family home (SafeLives, 2015).

5.3 Gloucestershire Hospitals NHS Foundation Trust

5.3.1. The homicide victim visited the Emergency Department on six occasions between 2007 and 2018 and there were significant time gaps between these attendances. He attended hospital infrequently but was prone to self-discharge and did not always attend follow-up appointments. On these occasions, clinicians followed the hospital's "Did Not Attend Policy" that was in place at the time.

5.3.2. The hospital reflected that their Emergency Department staff might usefully have intervened more in response to the kitchen fire in 2011. They considered there had been a lack of professional curiosity about the household composition and about whether the home was habitable for family members to return to. Neither had phone calls been made to the GP to make them aware of the discharge letters that were being sent. It cannot be guaranteed that GPs will read discharge letters, and so it has been common practice for the hospital to telephone when needing to alert them to issues of concern. As a result, the Trust have made recommendations for themselves to explore ways that they can effectively capture household composition in order to more easily identify when there are concerns about how other household members cope or help with a patient's illness or injury. They will also be drawing up guidance for Emergency Department staff on managing patients involved in house fires, including the need to establish where other inhabitants of the property are and whether the property is habitable prior to discharge.

5.3.3. Alcohol was a feature in the majority of the homicide victim's presentations and when he was under the influence of alcohol, he was considered to be generally uncooperative with treatment. At times, he was also considered to

be offensive and obstructive to hospital staff. Whilst staff were reportedly aware of the value of brief interventions to address alcohol concerns, the homicide victim's behaviour meant that their primary focus became persuading him to co-operate with dealing with his injuries.

5.3.4. Nonetheless, there were two hospital admissions, in 2007 and 2018, when, once sober and cooperative, alcohol treatment services could have been discussed with him. However, he did not display any alcohol withdrawal symptoms on either of these occasions and attention was being drawn on the latter occasion to monitoring his head injury. The panel recognised that brain injury was often connected to alcohol misuse and recognised the positive opportunity that automatic referral to alcohol treatment services could bring in such circumstances. The Trust has therefore made a recommendation to provide signposting information to alcohol services for all patients who attend Emergency Departments with alcohol-related presentations.

5.3.5. Neither the homicide victim nor his mother were routinely asked about domestic abuse when they presented to the Emergency Department. Both were seen alone, except when attending with the police, and their reported histories of how their respective injuries had occurred matched clinical findings and therefore did not appear to warrant additional curiosity. The Trust alerted the panel to its Domestic Abuse Policy (2016), its long-standing involvement in MARAC (2010) and its widespread domestic abuse training at induction on the signs and indicators of domestic and familial abuse. Moreover, since 2017, the Trust has based two Independent Domestic Violence Advisors (IDVA) from the independent, specialist service, Gloucestershire Domestic Abuse Support Service, within its hospitals.

5.3.6. Hospital based IDVAs have been shown to play a vital role in providing immediate support to domestic abuse victims, enabling their access to wider options and resources and supporting health colleagues in the identification

of domestic abuse within the hospital environment (Halliwell et al, 2019). Indeed the Gloucestershire Domestic Abuse Support Service have been able to demonstrate that their IDVAs have been working across a wide range of departments in the hospital: supporting victims, including familial abuse; training staff to identify and respond safely; providing a pathway including safe discharge plans, risk assessment and safety planning and working with the Mental Health Liaison and Drug and Alcohol Teams based there also. Its success can partly be marked by a threefold increase of referrals from the hospital into IDVA support. This development was therefore regarded by the panel to be best practice.

5.4 Gloucestershire Clinical Commissioning Group

5.4.1. Although the homicide victim attended the Emergency Department with some regularity, he visited his GP infrequently and not at all since the year 2000. Whilst the GP was sent the notifications of his discharge from hospital on each occasion, there was therefore no opportunity to pick these issues up with the homicide victim thereafter.

5.4.2. The homicide victim's mother attended her GP periodically for routine, non-domestic abuse related matters. The GP Practice was aware that she had attended the Emergency Department in November 2017 regarding an injury to her left hand, which, we have seen, she plausibly explained had happened at work.

5.4.3. However, given the prominence of alcohol within her life, the panel questioned the opportunities available within her presentations to enquire about and address her alcohol use. In particular, the homicide victim's mother had diabetes and regularly attended the diabetic clinic for routine tests and yet alcohol usage, self-reportedly at one unit per week, only featured in her notes on one occasion shortly before her diabetes was diagnosed in 2014.

5.4.4. The CCG Lead for Diabetes was consulted concerning how alcohol may be being monitored for diabetics and confirmed the approach that was taken in diabetes care: Gloucestershire GPs deliver a series of programmes in relation to diabetes including a programme which covers alcohol intake as a part of the syllabus on diet. This programme is delivered in a manner which is more akin to coaching around healthier lifestyles with an emphasis on continued engagement with patients. In this way, it was recognised that there was a risk of dis-engagement with patients if they felt judged about their behaviours and that dis-engagement with the GP carried its own risks for the patient. This may dissuade GPs from probing too far on issues such as problematic alcohol use and the current national contract for GPs does not require alcohol usage to be measured by primary care at diabetes patient's annual assessment[10]. This is not to say that further questions about alcohol may not be clinically generated, however, as alcohol usage did not feature in the homicide victim's mother's notes, it is not known whether she masked her use of alcohol within any discussions during the diabetes reviews as it is not a care process that is measured under the current contract.

*5.*4.5. The panel was made aware that there is currently much debate at a national level concerning how diabetes lifestyle should be addressed within primary care and recommended that this report be shared with the Department of Health and Social Care in order to inform that debate*.*

*5.*4.6. However, at the same time, the panel was made aware of a pilot that was being undertaken by Gloucestershire Domestic Abuse Support Services to provide specialist input into primary care services locally. A team of GP development and Support Workers have been working across the county, offering training around the identification of domestic abuse and support to

[10] The current contract regarding diabetes requires eight care processes, including blood pressure cholesterol, renal function and smoking status, to be measured at a patient's annual assessment.

respond to disclosures. Within this project, they have developed a Champions Network of GP practices that receive enhanced training and support and who develop best practice in the local primary care response to domestic abuse.

6. Thematic Analysis, Learning & Recommendations

6.1 The emerging picture of domestic abuse in the household

6.1.1 A key function of domestic homicide reviews is to contribute to a better understanding of domestic violence and abuse (Section 7, Multi-Agency Statutory Guidance, 2016). Although the homicide victim was ultimately subject to unlawful killing from his mother, the review heard how his mother had herself reported domestic abuse from her son as early as 2007. The panel therefore considered what might be known about family dynamics and domestic abuse in the household as a whole.

6.1.2 The panel heard no evidence or indication that the homicide victim had been subject to domestic abuse prior to his unlawful killing but identified that the police had received five reports of his disorder or domestic abuse within the home over these years. The first indication of domestic abuse, reported by his mother in 2007, provided a detailed account of her experiences in the household. She described how her son assaulted her weekly, had pushed her that day and how he was wrecking the house in a drunken state. Although later changing her mind, this was the only time that his mother wanted him to be prosecuted. It is not unusual for domestic abuse victims to withdraw their allegations against their abusers (CPS, 2017) and this may be particularly understandable in the case of abuse of parents as shall be considered further. It was therefore reassuring to find that a major focus of Gloucestershire Constabulary's more recent, *Domestic Abuse*

Matters training has been around building a rapport and relationship of trust with victims.

Learning Point: Getting It Right the First Time
Our response to a first report of domestic abuse will usually be critical in determining whether they have trust and confidence to approach us for help in the future.

Learning Point: Withdrawal of Complaints.
It is not uncommon for victims of domestic abuse to withdraw their support for prosecution after a crisis. Building a rapport with victims at this time is crucial in order to understand the victim's reasons and whether further action or evidence gathering may be appropriate.

6.1.3 After this earliest report of domestic abuse in 2007, the circumstances of each report to the police thereafter would have been far from clear for attending officers. Each incident involved the homicide victim and his parents each being intoxicated, and officers were generally unable to establish that any crime had occurred.

6.1.4 There were differences of opinion about what was happening in the household at the time. Wider family members identified that there were verbal arguments between the three whilst they were intoxicated and that their alcohol consumption had increased after the parents had retired. After retirement the three members of the family were home all day together and the wider family recognised that this will have put a strain upon their relationship. However, they did not consider that any party was frightened of the other. Nonetheless, a neighbour had observed that the homicide victim had become increasingly domineering and controlling of his parents.

6.1.5 A local resident had witnessed a number of incidents since the fire in 2011, where the homicide victim's mother had fled her home after arguments in the home and appeared very frightened. His mother was described as tiny and frail and appeared much older than her years.

6.1.6 As time had gone on, the homicide victim's father was open with one neighbour about the fact that he and his wife were increasingly living in their locked bedroom, eating their meals there and barely venturing out.

Learning Point: Escalation
Domestic abuse is rarely a one-off incident and needs to be considered as a pattern of repeated and often escalating abuse and coercive control. Agencies need to consider the known history of domestic abuse to assess the threat and risk from domestic abuse effectively.

Familial economic abuse

6.1.7 It was known to the police that the homicide victim largely relied upon his parents for his income, despite his age. The review considered how the family dynamics created this culture of financial dependency and heard from wider family members that the homicide victim would not have had the confidence or social skills to make a claim for benefits when he was not working. Although, his parents had claimed welfare benefits in earlier times, their family considered that the parents may not have been aware that their son could claim welfare benefits for himself. This financial dependency appears to have been exacerbated by the homicide victim's problematic alcohol use and he was observed making excessive demands of his parents to fund his alcohol and cigarettes. It appeared that the locks on the bedroom door were at least in part, to prevent these excessive demands and the homicide victim could be heard by neighbours constantly banging to get into the bedroom for this purpose. Irrespective of the homicide victim's motivation in this regard, the impact of his behaviour is one of economic abuse in so far as his behaviours interfered with his parent's ability to acquire, use and maintain economic resources.

6.1.8 Only the police had a vantage point from which to recognise the potential significance of the homicide victim's financial dependence upon his parents

and they rightly recorded this within a particularly detailed VIST. We have seen how developments in local responses to vulnerable people in the period since this time, have meant that the VIST would now have had multi-agency scrutiny within the MASH. However, what was less clear was whether this financial dependency would have been seen, then or now, by the agencies concerned as an indicator of domestic abuse. Indeed, research for the College of Policing into the application of the DASH has demonstrated that police officers rate the significance of financial issues as a particularly low risk despite a domestic abuse perpetrator's control of money being an important risk indicator (Robinson et al., 2016:24).

6.1.9 Sharp-Jeffs and Learmouth elaborate these risks by referring to economic abuse as coercive in so far as, "…it rarely takes place in isolation. Challenge is dangerous, compelling a victim to act in accordance with the abuser's wishes rather than their own" (2017:4). It is not known whether the homicide victim's economic abuse created a climate of fear for his parents and it should be noted that the wider family did not think that any member of the family was in fear of the other. It was also noted that the wider family did not believe that his parents were ever left short of money.

6.1.10 Nonetheless, a recommendation is made to promote awareness of the indicators of economic abuse and its significance to understanding risk.

Learning Point: Economic Abuse refers to behaviours that interfere with an individual's ability to acquire, use and maintain economic resources, including money, belongings and home. It rarely happens in isolation and should be seen as both coercive and controlling. As such it is an important indicator of risk in domestic abuse.

Recommendation 1:
The Domestic Abuse and Sexual Violence Co-ordinator, in conjunction with Safer Gloucestershire, should promote awareness of the indicators of economic abuse and seek assurance from agencies that practitioners are able to identify and respond to these indicators.

6.1.11 In these ways, the review has identified allegations and indicators of domestic abuse since 2007 in the forms of physical abuse, isolation, economic abuse and coercive control. The extent and impact of the abuse is not known. However, each of these features of domestic abuse may well have become exacerbated because of the nature of the parent-son relationship.

Experiencing domestic abuse as an older parent from an adult son

6.1.12 Recent research into domestic homicides involving older people has identified a number of key themes which arise consistently in the lives of those involved, including alcohol use, economic abuse and a history of domestic abuse (Benbow et al., 2018). Each of these factors has been found to be relevant in this case. Aside from infrequent calls to the police, the family did not seek help from other agencies for any of these issues despite advice and guidance from family and neighbours. This calls into question the barriers that they may have faced in seeking help.

6.1.13 Despite significant policy attention being drawn towards domestic abuse in recent years, parent's experiences have received comparatively little attention (Bows, 2018). For younger parents, national guidance has emphasised that isolation, stigma, shame, guilt and fear are particular barriers in seeking help as well as the fear of blame and responsibility for the shortcomings in their own parenting (Home Office, 2015b:5). For older parents, this may be exacerbated by their being unfamiliar with, and less likely to be engaged with, services and for the services to be less relevant and responsive to their particular needs (Bows, 2018:16). Moreover, generationally held attitudes may make it even harder for older people to understand their experiences as abuse.

6.1.14 Research has found that, "… Older victims are likely to have grown up in a time where the home was a private domain, and it would not have been deemed socially acceptable to discuss matters that occurred behind closed doors". (Safe Lives, 2016:15). The homicide victim's siblings and neighbours each advised the parents about how to access help and spoke about finding alternative accommodation for the homicide victim, which the parents declined. Wider family members considered that there was deep affection within the family but also that the homicide victim's parents would not have thought that their son was capable of living independently. Those close to the family agreed that the father had a strong sense of responsibility for his son as well as a firm belief in self-reliance and independence.

6.1.15 In terms of raising awareness within the community about domestic abuse and the help that is available, the review was presented with an extensive multi-agency, domestic abuse, communications and engagement plan with the vision,

"Individuals, families and communities who are at risk of, or exposed to, domestic abuse and/or sexual violence are able to access information and support to minimise harm, and to maintain healthy relationships."
(Gloucestershire Take A Stand, 2017).

6.1.16 The zero-tolerance plan, which covers all the services in Gloucestershire that are signatories to county-wide Domestic Abuse & Sexual Violence Commissioning Strategy and Outcome Framework, provides an ideal platform from which to target public awareness of familial domestic abuse for older people and awareness for the practitioners who need to be responding to them.

Learning Point: Older parents may struggle to define their experiences of abuse from their grown-up child and face particular barriers of stigma, shame, guilt and feelings of responsibility for their abuse and be particularly isolated from support.

Recommendation 2:
The DASV Coordinator will lead a project to promote targeted public awareness with older people around familial abuse, with the support of the organisations on both Safer Gloucestershire and the Safeguarding Adult Board.

Recommendation 3:
The DASV Coordinator should raise professional awareness of the barriers and risks that older people face when they experience familial domestic abuse from their children and seek assurance from agencies that practitioners are able to recognise these barriers and respond effectively, with the support of both Safer Gloucestershire and the Safeguarding Adult Board.

Potential Contributory Factors

6.1.17 These barriers may have been exacerbated further as the homicide victim's father shared concerns about his son having a learning disability with a neighbour who has professional experience in this area.

6.1.18 There was no indication that a learning disability had been identified or diagnosed within the homicide victim's childhood. Having said that, it would not have been unusual to miss if the disability was mild.

6.1.19 This draws us to question of whether some, or all, of the homicide victim's abusive behaviour could be attributed to challenging behaviour arising from a learning disability. Whilst it is undoubtedly the case that having a learning disability does **not** imply that an individual will use violence or abuse. NICE guidelines (2015) recognise that it is relatively common for people with a learning disability to develop behaviour that challenges, describing the context for such behaviour as follows:

> *"Some people with a learning disability display behaviour that challenges. 'Behaviour that challenges' is not a diagnosis and is used … to indicate that although such behaviour is a challenge to services,*

> *family members or carers, it may serve a purpose for the person with a learning disability (for example, by producing sensory stimulation, attracting attention, avoiding demands and communicating with other people). This behaviour often results from the interaction between personal and environmental factors and includes aggression, self-injury, stereotypic behaviour, withdrawal, and disruptive or destructive behaviour. It can also include violence, arson …, and may bring the person into contact with the criminal justice system*. (NICE, 2015:6)

6.1.19. There are certainly aspects of the homicide victim's behaviour that appear consistent with this description. However, the homicide victim's behaviour is equally consistent with problematic alcohol use, acquired brain injury or with the behaviour of a perpetrator of domestic abuse. Nevertheless, the relationship between learning disability and the perpetration of domestic abuse is a poorly understood area of social policy (Swift et al, 2017).

6.1.20. The review also heard how the homicide victim's behaviour was thought, by those close to him, to have become worse after he had suffered an assault and a fractured skull in April 2018. No adverse symptoms other than hearing loss, had been identified following his overnight stay and observation in hospital. Aside from a hearing loss appointment, the onus was on the homicide victim to return to hospital if he experienced any delayed or future symptoms. Whilst some of the victim's behaviour may be consistent with those common behavioural changes following acquired brain injury (Kratz et.al 2017; Tam et al. 2015), it is not known whether the homicide victim experienced any such symptoms thereafter or, if so, was reluctant or unable to seek help. It should be noted that on the earlier occasion of the fire, the homicide victim had returned to hospital with ongoing health concerns suggesting that he had not previously been averse to seeking medical help, although the wider family alerted the review to the anxiety that he would have felt attending such appointments.

6.1.21. Whilst some of those close to the homicide victim may have considered that his behaviour was partly or solely due to a learning disability or acquired head injury, we have seen that the review found no evidence to support these assertions. Neither could it have been assumed that had these factors been present, that they would have led to his abusive behaviour.

Learning Point: The motivation for an individual's violent and abusive behaviour may be complicated by virtue of other factors such as learning disability or acquired brain injury. However, their victim may feel no less frightened, overwhelmed or powerless. On the contrary, they may feel greater responsibility to care for their abuser or tolerate and excuse their behaviour.

6.2 Alcohol and domestic abuse

6.2.1 In many ways, the family was under the radar of services, only coming to the attention of emergency services infrequently in relation to problematic alcohol use. Whilst those close to the family considered that their alcohol misuse was increasing, their contact with agencies still remained infrequent.

6.2.2 We have seen that the homicide victim came to the attention of the police in respect of alcohol related disorder both within and outside of the home: nine times in public and five times in the home. His public, alcohol-related disorder was dealt with on two occasions through alcohol management techniques within the night-time economy:[11] a banning order and the Pubwatch[12] scheme. In earlier years, he was cautioned for assault and criminal damage; had CS spray deployed and on two occasions was the victim of serious assault whilst intoxicated. Gloucestershire Constabulary considered whether more could have been done to encourage the homicide victim to engage with alcohol treatment services at these times but

[11] Night-time economy is a term used to refer to an area's entertainment and nightlife, usually involving the sale of alcohol and requiring management of alcohol related disorder.
[12] Pubwatch is a scheme which aims to provide a safer drinking environment in all licensed premises

concluded that there was not capacity within police resources to respond in this way to individuals outside of the custody suite.

6.2.3 Likewise, we have seen that each of the reports to the police from the family home were at times when one or more family members were intoxicated. Guidance produced by Alcohol Concern and the AVA Project (2016) concerning change-resistant drinkers, recognised that problematic alcohol use and poor engagement with alcohol treatment featured regularly in domestic homicide reviews. Similar findings have been evident throughout domestic homicide and serious case reviews (Home Office, 2016; Robinson et al, 2018).

6.2.4 Alcohol Concern and AVA's research found that in only thirty-six per cent of cases where the individual had a problem with alcohol, was a referral made to a specialist alcohol service (2016:12). In this case too, of the five times that the police were called to the home and the four times that the homicide victim attended the Emergency Department where alcohol was a feature of the presentation, no referrals or signposting to alcohol treatment services was undertaken and this has been addressed in each of the individual agency plans. Moreover, GPs have also recognised the need to refer their patients to treatment services and, by way of a prompt, CGL referral links have been added to their computer desktop displays.

6.2.5 Nonetheless, the relationship between alcohol and domestic abuse is far from straightforward. Evidence reveals that alcohol should not be seen as a cause or explanation for domestic violence and abuse but more as a potentially inhibiting or aggravating factor (Alcohol Concern and AVA, 2016). For abusers, problematic alcohol use has been found to impact upon their abuse in relationships far beyond the periods of intoxication, perpetuating and extending the reach of coercive control (Stark, 2007:228). Perhaps of most relevance, is that some perpetrators pose greater risks to their partners, not when they are most intoxicated, but when they are

withdrawing or are struggling to fund their alcohol use (Gilchrist et al., 2019). This situation may indeed be how the homicide victim's parents felt when he was relentlessly pressurising them for money for more alcohol.

6.2.6 On the other hand, the use of alcohol is widely understood to be a means of dealing with traumatic life experiences (Alcohol Concern and AVA, 2016:17). For the homicide victim, the wider family described how problematic alcohol use had been a consistent part of his life and he had not known anything else growing up with parents who, from their perspective, had become alcoholics early in his childhood. The foundations of the parent's problematic alcohol use are not known.

6.2.7 However, Stark (2007) describes how some individuals self-medicate with drugs or alcohol in order to manage their experiences of abuse. Stark goes on to recognise that some victims who have been subjected to the 'intimate terror' of domestic abuse over many years have taken matters into their own hands mounting grievous attacks on their abusers, whether this is with or without direct provocation or retaliation at that moment in time (2007:152). As the homicide victim's mother died before her trial, it is not known whether this picture of traumatisation aligned with her experience and reason for her increasing use of alcohol over time, as well as her fatal assault of her son, but it would be consistent with the well-evidenced experience of others.

Learning Point: Victims may often use alcohol as a means to cope with their experiences of domestic abuse. Substance misuse, particularly in women, needs to be recognised as a symptom of abuse and be followed up by safe routine enquiry on domestic abuse.

Recommendation 4:
A joint working protocol be introduced between Gloucestershire Domestic Abuse Support Services and CGL to strengthen referrals and partnership working between the two specialist fields.

6.3 Social Isolation

6.3.1 The family continued to have some contact with their immediate family who recognised that the parents were very private people. Nonetheless, both son and parents were isolated from formal sources of support with which to deal with the deepening alcohol use and abuse that they appeared to be experiencing.

6.3.2 Social isolation is a common outcome of domestic abuse. In some instances, it forms part of a deliberate pattern of coercive control: preventing victims of domestic abuse from seeking help and increasing reliance upon the abuser. Whilst the intention in this case was not known, the degree of social isolation that was evident was unmistakable: being increasingly forced to lock themselves in their room to protect against an onslaught of threats and demands by their son.

6.3.3 It was therefore reassuring to find that within Gloucestershire, social isolation has been recognised as a major concern for the health and well-being of its population and has been made a shared priority in both its community safety and health and well-being strategies. These strategies seek "to enable local people to take an active role in building and nurturing strong social networks and vibrant communities" (Gloucestershire Health and Well-Being Board, 2019:20). It was not known why the homicide victim's father did not take up the offer by family and neighbours of help and support as well as finding alternative accommodation for their son, but the family could certainly have benefited from a stronger inclusion in community life and familiarity with the support services that accompanied it.

6.3.4 HMICFRS' recent analysis of the response to crimes against older people, recognised that older people were more likely to have diminishing social circles and support networks but "there appeared to be low levels of referral

and signposting to support services at any point in the reporting process. This left some … [older people] … feeling unsupported and overwhelmed" (2019:5). In this case, the various reports to the police over the decade referred to the homicide victim 'going mad'; 'breaking things up'; 'going mental and smashing things up' whilst intoxicated. At such times his parents may well have felt unsupported and overwhelmed. In this way, agencies should be using every opportunity to connect older people to services and support networks.

Learning Point: Domestic abuse often involves and relies upon social isolation: preventing the victim from gaining formal or informal support and preventing them breaking free from their abuser's control. This compounds the social isolation that older people experiencing domestic abuse are more likely to experience.

Recommendation 5:
Safer Gloucestershire and Gloucestershire Health and Well-Being Board to consider the particular features of domestic abuse related social isolation and include actions to address this within their shared priorities to tackle social isolation.

6.4 Early Identification of Domestic Abuse in Health Settings

6.4.1 Both the initiative of domestic abuse primary care workers across the county and the co-location of IDVAs within the hospital, were seen to be providing a useful framework for early identification and help, particularly for older victims of domestic abuse who may not routinely access other services. Had these services existed at the time, they could well have been best placed to reach the family when they accessed health services.

6.4.2 It was noted that, at the time of writing this report, that both of these initiatives had been part of a pilot which was due to end in March 2020. The review has therefore made recommendations for Safer Gloucestershire to consider the evaluations of the Early Identification of Domestic Abuse in Health Programme.

Recommendation 6:
Safer Gloucestershire to consider the evaluation of the Early Identification of Domestic Abuse in Health Programme, including the introduction of an IDVA in the hospital setting and domestic abuse workers within primary care, and respond to its findings

7. Conclusion

7.1 This review has considered the circumstances leading to the unlawful killing of a thirty-five-year-old man by his sixty-five-year-old mother. The review heard how the lives of this very private family were blighted by long term problematic alcohol use. There were also indications of the homicide victim's domestic abuse towards his parents which may have been compounded by an unrecognised learning disability or undiagnosed acquired brain injury. However, the family was largely under the radar of services and was seen to be particularly isolated from formal sources of support and tackling social isolation had already been recognised as a strategic priority for the local area.

7.2 The review has consolidated our knowledge about domestic abuse in so far as:

- there is a critical need to get our response right the first time, as in this case domestic abuse was only reported once twelve years prior to the killing
- economic abuse rarely takes place in isolation and identifying economic abuse can help agencies identify other forms of abuse in a household

- that older parents facing abuse from adult sons also face particular barriers to identifying their experiences as abuse and seeking help or taking action against their child

7.3 The review has also considered the complex relationship of problematic alcohol use to domestic abuse and examined this alcohol use from the perspective of both the abuser and abused. The review particularly highlighted the important role of health agencies in routinely enquiring about both domestic abuse and alcohol and signposting individuals to treatment services thereafter. Gloucestershire's Early Identification of Domestic Abuse in Health Programme is seen to be good practice and particularly so for older victims of domestic abuse who may access fewer services than younger people.

8. Recommendations

8.1 Overview Report Recommendations

Recommendation 1:

The Domestic Abuse and Sexual Violence Co-ordinator, in conjunction with Safer Gloucestershire, should promote awareness of the indicators of economic abuse and seek assurance from agencies that practitioners are able to identify and respond to these indicators.

Recommendation 2:

The DASV Coordinator will lead a project to promote targeted public awareness with older people around familial abuse, with the support of the organisations on both Safer Gloucestershire and the Safeguarding Adult Board.

Recommendation 3:

The DASV Coordinator should raise professional awareness of the barriers and risks that older people face when they experience familial domestic abuse from their children and seek assurance from agencies that practitioners are able to recognise these barriers and respond effectively, with the support of both Safer Gloucestershire and the Safeguarding Adult Board.

Recommendation 4:

That a joint working protocol be developed between Gloucestershire Domestic Abuse Support Services and CGL to strengthen referrals and partnership working between the two specialist fields.

Recommendation 5:

Safer Gloucestershire and Gloucestershire Health and Well-Being Board to consider the particular features of domestic abuse related social isolation and include actions to address this within their shared priorities to tackle social isolation.

Recommendation 6:

Safer Gloucestershire to consider the evaluation of the Early Identification of Domestic Abuse in Health Programme, including the introduction of an IDVA into the hospital setting and domestic abuse workers within primary care, and respond to its findings

8.2 Individual Agency Recommendations

8.2.1 Gloucester Constabulary

That Gloucestershire Constabulary, in conjunction with CGL, should continue to recognise and assist persons presented in custody with alcohol and substance abuse to try and reduce offending and rehabilitate them.

That Gloucestershire Constabulary should via the Multi-Agency Safeguarding Hub daily domestic abuse meeting seek to identify repeat standard risk cases and escalate concerns utilising the skills and experience of multi-agency staff present. Particularly if drug, alcohol or mental health is a feature for any of the parties.

8.2.2 Gloucestershire Hospitals NHS Foundation Trust

Provide signposting information to Alcohol Services for all patients who attend our Emergency Departments with alcohol-related presentations.

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Appendix 1: Action Plans

Overview Recommendations

Recommendation 1:
The Domestic Abuse and Sexual Violence Co-ordinator, in conjunction with Safer Gloucestershire, should promote awareness of the indicators of economic abuse and seek assurance from agencies that practitioners are able to identify and respond to these indicators.

REF	Action (SMART)	Scope	Lead	Key milestones	Target date	Completion Date and Outcome
1.1	DASV Communications plan to include campaign on economic abuse for both professionals and the public	Local	County DASV Strategic Coordinator	1. DASV comms plan in place for 2020/21 and annually 2. Campaign rolled out	Completed by end of 2021	August 2020: Economic abuse was the monthly theme for the comms plan. Social media content was developed and circulated, radio interviews were held and factsheets were circulated for professionals and employers.
1.2	DASV countywide training to include awareness of the indicators of economic abuse	Local	County DASV Strategic Coordinator	DASV training to be amended to include indicators of economic abuse.	June 2020	August 2020: Police training is currently under review and will ensure it includes economic abuse. Plans to revise any countywide training

						are currently on hold until services are operating outside of covid recovery phase.
1.3	DHR learning event to be held for all professionals in the county.	Local	County DASV Strategic Coordinator	Learning event held.	Following DHR publication	

Recommendation 2:
The DASV Coordinator will lead a project to promote targeted public awareness with older people around familial abuse, with the support of the organisations on both Safer Gloucestershire and the Safeguarding Adult Board.

REF	Action (SMART)	Scope	Lead	Key milestones	Target date	Completion Date and Outcome
1.1	Small task group to be established to develop plan for public awareness with older people.	Local	County DASV Strategic Coordinator	1. Task group established 2. Action plan developed for campaign and engagement	Completed by end of 2020	August 2020: Comms plan for 2020 includes plan to have a month long campaign on older people. A task group will be established later in 2020 to consider comms activity for 2021.
1.2	DASV Communications plan to include campaign on older people and familial abuse	Local		1. DASV comms plan in place for 2020/21 and annually	April 2020	August 2020: Comms plan for 2020 includes plan to have a month long campaign on older people and familial abuse. It will also be picked up in future comms plans as part of ongoing awareness raising.

Recommendation 3:
The DASV Coordinator should raise professional awareness of the barriers and risks that older people face when they experience familial domestic abuse from their children and seek assurance from agencies that practitioners are able to recognise these barriers and respond effectively, with the support of both Safer Gloucestershire and the Safeguarding Adult Board.

REF	Action (SMART)	Scope	Lead	Key milestones	Target date	Completion Date and Outcome

1.1	Small task group (as per rec. 2)to be established to agree process for training safeguarding professionals with adult safeguarding.	Local	County DASV Strategic Coordinator	1. Task group established 2. Action plan developed for training and awareness plans	Completed by end of 2020	
1.2	DHR learning event to be held for all professionals in the county.	Local	County DASV Strategic Coordinator		Following DHR publication	

Recommendation 4:
A joint working protocol be introduced between Gloucestershire Domestic Abuse Support Services and CGL to strengthen referrals and partnership working between the two specialist fields.

REF	Action (SMART)	Scope	Lead	Key milestones	Target date	Completion Date and Outcome
1.1	Joint working protocol	Local	GDASS/CGL	Protocol developed Protocol embedded		

Recommendation 5:
Safer Gloucestershire and Gloucestershire Health and Well-Being Board to consider the particular features of domestic abuse related social isolation and include actions to address this within their shared priorities to tackle social isolation.

REF	Action (SMART)	Scope	Lead	Key milestones	Target date	Completion Date and Outcome
1.1	Safer Gloucestershire Secretariat to develop plans to address social isolation alongside HWB	Local	Secretariat members	Actions to address social isolation included in the Safer Gloucestershire action plan.	TBA	

Recommendation 6:
Safer Gloucestershire to consider the evaluation of the Early Identification of Domestic Abuse is Health Programme, including the introduction of an IDVA into the hospital setting and domestic abuse workers within primary care, and respond to its findings

REF	Action (SMART)	Scope	Lead	Key milestones	Target date	Completion Date and Outcome
1.1	Safer Gloucestershire Secretariat to review evaluation and develop plans to respond to findings.	Local	Secretariat members	Actions to address evaluation included in safer Gloucestershire action plan	TBC	

Individual Agency Action Plan: *Gloucestershire Constabulary*

Recommendation 1: That Gloucestershire Constabulary, in conjunction with CGL, should continue to recognise and assist persons presented in custody with alcohol and substance abuse to try and reduce offending and rehabilitate them.						
Desired outcome from the recommendation: CGL attempting to engage with all persons that present in custody with alcohol/substance abuse to provide intervention and rehabilitation.						
REF	**Action (SMART)**	**Scope**	**Lead**	**Key milestones**	**Target date**	**Completion Date and Outcome**
1.1	Increase awareness of CGL provision amongst all staff utilising custody. Consideration to be given to how best to deliver this via C+E team.	Local	*DCI USHER*	Quarterly reviews.	01/01/2021	
1.1	Awareness input from Custody Chief Inspector/CGL to Custody Sergeants on training days.	Local	*DCI USHER*	Quarterly reviews.	01/01/2021	
1.3	Ensure custody record access given to CGL staff to allow them to update records directly.	Local	*DCI USHER*	Quarterly reviews.	01/01/2021	
1.4	As part of risk assessment completed prior release, Custody Sergeant to ensure CGL compliance.	Local	*DCI USHER*	Quarterly reviews.	01/01/2021	
1.5	PACE Inspectors to dip sample records to ensure compliance.	Local	*DCI USHER*	Quarterly reviews.	01/01/2021	
1.6	Independent Custody Visitors to check records for compliance as part of their custody scrutiny.	Local	*DCI USHER*	Quarterly reviews.	01/01/2021	

Recommendation 2:
That Gloucestershire Constabulary should via the Multi-Agency Safeguarding Hub daily Domestic Abuse meeting seek to identify repeat standard risk cases and escalate concerns utilising the skills and experience of multi-agency staff present. Particularly if drug, alcohol or mental health is a feature for any of the parties.

Desired outcome from the recommendation: To prevent repeated lower level cases escalating into more serious offences by early intervention and as a consequence ensure than an opportunity to intervene is not missed.

REF	Action (SMART)	Scope	Lead	Key milestones	Target date	Completion Date and Outcome
1.1	First responders to be reminded of importance of gathering information pertinent to potential reason for DA on VIST. In particular any issues appertaining to drugs, alcohol or MH.	Local	*DCI USHER*	Quarterly reviews.	01/01/2021	
1.2	Frontline supervisors to ensure history review before endorsing risk level. Considering whether	Local	*DCI USHER*	Quarterly reviews.	01/01/2021	
1.3	DAST Supervisor to ensure identification at the morning MASH meeting of any low level patterns and change risk level accordingly.	Local	*DCI USHER*	Quarterly reviews.	01/01/2021	

Individual Agency Action Plan: Gloucestershire Hospitals NHS Foundation Trust

Recommendation 1:
Provide signposting information to Alcohol Services for all patients who attend our Emergency Departments with alcohol-related presentations.

REF	Action (SMART)	Scope	Lead	Key milestones	Target date	Completion Date and Outcome
1.1	Contact county commissioners to find out what signposting information is already available	Local	Safeguarding Adults Lead	-	-	Completed 21/11/19 Advised to contact DART team Advised that national alcohol CQuIN would cross-support this recommendation
1.2	Review current signposting information with DART team	Local	Safeguarding Adults Lead	-	-	Completed 02/12/19 DART team currently have signposting information designed to raise profile of their service to staff who might refer a patient, not for giving to a patient
1.3	Work with DART team to design signposting material	Local	Safeguarding Adults Lead	1. Agree content 2. Agree funding with commissioners, including ongoing costs 3. Order flyers	31st January 2020	
1.4	Launch signposting material in Emergency Department, acute medical wards and outpatient areas	Local	Safeguarding Adults Lead	1. Include option to give signposting material in all Emergency Department guidelines 2. Stock both Emergency Departments and establish re-order ability	28.02.20	

				3. Involve professionals and volunteer staff in stocking leaflet racks 4. Ensure Staff Support Hub has adequate stock and re-order ability		