EXECUTIVE SUMMARY

Case 5

Under Section 9 of the Domestic Violence Crime and Victims Act (2004)

in respect of the death of a

43 year old woman on 30th January 2014

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LIST OF ABBREVIATIONS

DfEE	Department for Education and Employment – HM Government
DHR	Domestic Homicide Review
EHE	Elective Home Education
HELO	Home Education Liaison Officer
IDVA	Independent Domestic Violence Advisor
IMR	Individual Management Review
LBSS	Learning Behaviour Support Services
MARAC	Multi-Agency Risk Assessment Conference
MGF	Maternal Grand Father
MGM	Maternal Grand Mother
NHS	National Health Service
NICE	Nation Institute for Clinical Excellence
PKU	Phenylketonuria – a congenital genetic condition
SENCO	Special Educational Needs Co-ordinator – Education
SEST	Specialist Education Support Teams
SWCSP	South Worcestershire Community Safety Partnership
WHASCAS	Worcestershire Heath and Social Care Access Centre

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Introduction

For the purposes of this report and to protect the identity of those involved a key will be used throughout the report as follows:

The Victim - The deceased and mother of perpetrator

The Perpetrator - The son of deceased

H1 - The husband of the Victim and father of S2 and S3 (deceased)

S1 - Older brother of the Perpetrator

S2 - Younger brother of the Perpetrator

MGM – Maternal grandmother and mother of the Victim

MGF - Maternal grandfather and father of the Victim

P1 - Former partner of the Victim and father of S1

P2 - Former partner of the Victim and father of the Perpetrator

The Victim was 43 years of age at the time of her death on 30th January 2014. She lived in rented accommodation in Worcestershire with H1, S1, S2 and the Perpetrator.

The Perpetrator was the middle son of three sons. He was born with significant medical problems, which necessitated medical intervention but the Victim chose not to engage with treatment which included an operation. Instead the Perpetrator selected regression therapy and homeopathic remedies.

The Victim and her family decided when S1 and the Perpetrator were young to move them from state school into private education, but for numerous reasons this was considered unsuitable, so the decision was made to seek Elective Home Education (EHE)

The Victim and family decided to leave the GP's surgery list. The family did not receive medical treatment from a GP although there was a period between the ages of 5 years and his late teens that the Perpetrator did not require any medical treatment.

As a result of his long term illness as a child, the Perpetrator missed a significant part of his early schooling, but, according to his family, he caught up whilst being Home Educated.

He also developed other medical conditions which the family consider were as a result of long term prescribed drugs and medication. His eyesight deteriorated to such an extent that he had problems seeing especially in darkness.

There is also evidence that during his early 20's, his mental health deteriorated.

The Perpetrator, supported by his family, chose to undergo regression therapy, sometimes through the world-wide-web and other times with a therapist in the south of England.

The relationship between the Perpetrator and his mother, the Victim, deteriorated during the latter months of 2013, mainly around the issue of his therapy and his mental condition affecting his behaviour.

A day before the attack, his mother and the Perpetrator argued resulting in him hitting her in the face.

On 30th January 2014, the Perpetrator went into his mother's bedroom armed with a knife and attacked her. She suffered multiple stab wounds in the attack, which was witnessed by MGM and S2, both of whom ran to the bedroom as a result of hearing the Victim's screams. S2 was also stabbed as he attempted to prevent the attack continuing.

The Victim was pronounced dead at the scene. The Perpetrator was arrested and detained in secure mental health accommodation until his appearance at Birmingham Crown Court on 13th February 2015 where the Court accepted a plea to Manslaughter on the ground of diminished responsibility. He was made subject to a Hospital Order.

The Terms of Reference, details of the Domestic Homicide Panel membership etc. are contained in Appendix A to this report.

Summary of Events

The family involved in this Domestic Homicide are white, British and although the Victim's religion is described by S1 as being Church of England; it is stated that she was not a regular attendee at Church. The family lived in rented accommodation in Worcestershire. The victim's parents (MGM & MGF) lived in a nearby town and were, and still are, very close to the rest of the family. The grandparents now live with H1, S1 and S2 in Worcestershire.

The Victim gave birth to S1 when she was 18 years of age, following a relationship she had with a man (P1) whilst she was travelling in Norfolk. He died from an alcohol related illness in 2008.

In 1990, the Victim met P2 whilst travelling in Yorkshire and the Perpetrator was born from that relationship. Shortly after the birth P2 moved away from the family back to Ireland and has not been seen since. He has not been traced or seen as part of this review process.

Hospital notes at the time of her pregnancy with her second child (the Perpetrator), indicated that the Victim expressed the view that she was unhappy about her first pregnancy and sought information about alternative delivery at home for the birth of the Perpetrator[1]. She requested aromatherapy instead of the conventional pain relief when in labour.

Four days after the birth, the child became unwell and was admitted to hospital suffering from bilateral hydronephrosis[2], resulting in septicaemia. According to the Victim and her family, the infection had been caused by the student midwife using dirty scissors to cut the umbilical cord.

At the Baby Clinic on 15th October 1991, the Victim stated that she had been advised not to have the child vaccinated.

In June 1992, there is a comment made in the medical notes following an outpatient's appointment to the effect that Mother was clearly continually worried about every little thing to do with the child. The Mother is described by the family as being a very caring person.

[1] A subsequent investigation by the Health Authority found that all allegations were unfounded and unsubstantiated.

[2] Bilateral hydronephrosis - literal meaning - "water inside the kidney" — refers to distension and dilation of the renal pelvis and calyces, usually caused by obstruction of the free flow of urine from the kidney.

In January 1993, there were significant medical conditions to warrant him being seen by a Clinical Psychologist. The Clinical Psychologist noted;

> 'Emphatic view of mother and grandmother that [the child's] difficulties arise from intermittent organic pain. They are frustrated with [Consultant Nephrologists] in BCH, who disagrees with them over this'.

The Victim was convinced that an organic problem was the cause of her son's problems and it was not related to psychological issues or stress. The Consultant noted that this was a difficult case to manage and he wanted to rule out any organic problem before embarking on intense programmes of emotional or psychological support.

The Victim however, attributed all of his previous symptoms to the antibiotics given as a prophylaxis. She had refused surgery for her son as she felt admission to hospital would upset him. She told the Consultant that the Nephrologist was not happy about this decision.

In April 1995 a Community Paediatrician conducted a child development assessment and found that the child had global development delay with speech and language delay. He was emotionally insecure and had difficulty in separating from his mother He was not yet toilet trained and had long standing renal problems. Mother was not keen for surgery. There was a thought that his hearing loss was due to Gentamicin but subsequent testing shows his hearing was normal.

From August 1995 until January 1998 the Victim followed homeopathic treatment for her son. However there appears to be a lack of follow up during those 3 years for a child who had health issues and was not seen by any medical professional. From August 1995 when he was 4 years of age, until 1998, when he was 7 years old he was 'under the radar' of medical services and this could be seen as a missed opportunity for intervention. The Victim stated she was told by a Doctor the child would not live beyond the age of 7 years and if he did, he would not survive through his teenage years. This statement is not supported by any medical records.

The Perpetrator's Education

In January 1998, Worcestershire County Council Education Department Special Education Support Team (SEST) requested a period of assessment to investigate difficulties the Perpetrator was having in language, understanding and thinking skills, reading and writing. As a result of the assessment, in June 1998, actions for the Perpetrator's class teacher, Special Educational Needs Co-ordinator, (SENCO) his parents and the Learning and Behaviour Support Service (LBSS) were raised. However the Victim disagreed with the manner in which her sons were being educated and they were removed from the state education system and educated at home under the Elective Home Education process.

It is important to note that there was no Departmental Guidance on Elective Home Education until August 2007. Pre-2007 the DfEE had published a leaflet on home education in England and Wales which reflected basic practice.

The records show that during the timescales of this report there were four WCC Home Education Liaison Officers who were in post whilst the boys were being home educated. On every request for information regarding the child's education the parents were able to demonstrate that a suitable education was taking place by providing detailed evidence of work. Parents informed the HELO of the Perpetrator's lack of confidence and learning difficulties and it was observed that his educational arrangements were suitable for his age, aptitude and ability. The Perpetrator was 10 years of age at this time.

The remit of the Home Education Liaison Officer during meetings with parents and children, was to make assessments of the suitability of the education being provided by parents according to age, aptitude, ability and any Special Educational Need the child may have. If there had been any concerns about the safeguarding the (HELO) would have referred the case to the Access Centre.

The Perpetrator and his older brother were home educated for the remainder of their school years. There was annual contact between the family and the Elective Home Education (EHE) Tutor but not necessarily the child. Seeing the child is not a requirement of the EHE scheme. There are no concerns about the outcome of EHE for the three boys in this family. All of them are highly intelligent and gifted musicians. The oldest son runs a very successful I.T. business.

The Birth of S2 and S3

During 2001, the Victim became pregnant again. She had decided not to have any medical support during her pregnancy. The pregnancy was to end in tragic circumstances. The Victim chose not to be medically examined throughout her pregnancy other than abdomen palpations, and insisted on a home birth. During the final stages of labour the midwife realised for the first time that the Victim was pregnant with twins and an ambulance was called.

Once at hospital, the Victim realised that the only safe way to deliver was by Caesarean Section.

S2 a boy, and S3 a girl, were born premature at 36 weeks gestation. S3 started fitting within an hour, she had no heart beat and required assistance with breathing and was intubated. Her prognosis was very poor. She was diagnosed with severe brain damage which was likely to worsen without further intensive care. The parents agreed to continue supportive care. However S3 did not improve and the parents were informed of the prognosis.

S3 died peacefully 4 days later and S2 survived. It is the family's view that the midwife 'panicked' when she realised that twins were to be born, and that one of the midwives was the same person that delivered the Perpetrator. Medical records do not support this.

The Victim and H1 made formal complaints to the Health Authority about the circumstances surrounding the birth of S2 and S3 and the death of S3. This was fully investigated and no evidence of mal-practice was discovered. The case was also referred to an Independent Convenor as the parents were unhappy with the result of the investigation who also found that there was no mal-practice during the care of the Victim and the birth of the twins.

Regression Therapy

By the time the Perpetrator was in his late teens, he was experiencing significant problems with his eye sight. No professional help was sought by the Victim to treat his eye problem, but the family are of the opinion that the condition was caused by the prolonged prescribing of his medication years before. They also state that by this time the Perpetrator was old enough to decide for himself if he wished to have treatment.

Due to the Victim's and the Perpetrator's loss in faith with the medical services, he turned to 'regression therapy'. H1 will say that this was because the Perpetrator lost interest in a number of pastimes and activities. MGF told Police that it was because there was a belief that regression therapy would heal him.

In June 2013, the Victim arranged an appointment for herself and her son to have regression therapy with a qualified dedicated practitioner of Quantum Healing Hypnosis. The Practitioner described the Victim's 'bizarre' behaviour at their appointment. She said the Victim told her she carries guilt for not making different decisions and that this related to her getting all her family to use a female homeopath who she now believed had poisoned them. She said she constantly suffered with noises in her head and that she spoke incessantly. The hypnotherapist considered that the Victim was putting herself before her son and didn't care whether he had a session or not. The Perpetrator had a session of hypnotherapy at which the Victim was present at all times. The hypnotherapist describes how she kept shaking her head as if what her son was saying was untrue and that she began adding information to what he was saying.

The family will say that they disagree with the comments that the Victim put herself first and that she did everything possible for her family especially the Perpetrator. All her decisions were researched and thoroughly thought through.

The family will say that following this regression therapy that the Perpetrator's character changed but that his eyesight improved and his arthritic knee and is kidney problems were cured completely. The family allege that the regression therapist had given him a means to self-help by quoting some words or self-hypnotising himself. As a result, his behaviour became increasingly challenging. He assumed the identity of famous dead people like Edward Elgar or Winston Churchill. He also claimed he was Jesus and locked himself in the toilet saying he was the voice of God. H1 states the Perpetrator said he was hearing voices. He would self-hypnotise and be in a trance like state for days.

The Perpetrator in his later years

Once in his later teens and then an adult, the Perpetrator made his own decisions about his health and well-being. There is no evidence to suggest that he lacked the mental capacity to make decisions and he maintained the families' view and chose to avoid any medical intervention whatsoever.

The Perpetrator demonstrated a skill and great pleasure in wood cutting and was a regular attendant at a local forest woodland trust centre, where he would use power tools and axes to cut trees down, harvest cut wood and also partake in woodcarving. He was nearly always accompanied there by his older brother and/or his grandfather, on whom he relied for transport. Whilst at the trust he passed a woodland management course and developed an interest in woodwork.

Police Officers had two interactions with the Perpetrator when he was found walking firstly along lanes and secondly at the side of busy roads. In August 2013 an Officer submitted a Vulnerable Adults Report which was forwarded to West Mercia Police Vulnerable Adults Department. The referral was received by Worcestershire Health and Social Care Access Centre (WHASCAS) 8 days after he was found occurred and was categorised as not to require an immediate response. In fact enquiries into this referral did not commence until 10th September 2013, 11 days after the referral was made and 19 days after the incident occurred.

Subsequently a referral was made by West Mercia Police to Adult Social Care about the Perpetrator being found in a confused state during the early hours of 22nd August 2013.

There followed 5 attempts by WHASCAS to contact the Perpetrator by telephone but on each occasion there was either no reply or the Customer Advisor was told to ring back.

Eventually, on 17th September 2013, the Victim returned a call from WHASCAS Customer Advisor. She explained that the Perpetrator was at work. She explained about his ongoing sight problems were related to health problems that he had had since his birth. She added that she would inform her son of the telephone contact so that he was aware that he could make contact for advice and assistance if necessary. The family will say that there was no intention by the Perpetrator to speak to anyone about his problems.

A few days before the end of January 2014 he told his mother he hated her and the family were all evil.

Between 18.15 and 18.18 hours on 28th January 2014, West Mercia Police received three calls from members of the public reporting a man lying on the grass verge at the side of the main A38, near Droitwich, Worcestershire. Police Officer was sent and found the Perpetrator sitting in a lay-by. He stated that he had been walking for some time and he had been trying to get to his Aunt's house. The Perpetrator was taken home by the Police Officer.

When interviewed by Police after the death of the Victim, MGF stated later that day, 28th January 2014, and the Victim gave the Perpetrator an ultimatum, which was he either continued with regression therapy or received conventional medicine at a local psychiatric hospital. His reaction to that was to punch his mother in the face. The following day on 29th January 2014, his mother again gave the Perpetrator the same ultimatum. He became aggressive and refused to do anything or go anywhere. As a result the Victim telephoned the police to speak to the officer who had found him wandering the day before. The Victim spoke to someone at the police station who advised her to take her son to the local hospital. (There is no record of this call in any West Mercia police systems and it is presumed this was just a non-recorded telephone conversation between the Victim and an Officer or Police Staff who answered the call).

The Perpetrator chose to go to the local psychiatric hospital and MGM and MGF started to drive him there. On route however, he changed his mind and promised to continue with alternative therapy. He was taken back home before reaching the hospital and for the rest of the day was described as being very quiet.

The following day, 30th January 2014, the Perpetrator went out walking. When he returned at midday his mother was still in bed. She then spent time contacting a "medium" in order to arrange an appointment for her son. The "medium" refused to see her son saying she wasn't insured to treat such severe cases.

The Victim called the Perpetrator upstairs to her bedroom to talk to him and whilst in the bedroom he produced a knife and stabbed his mother several times about the body. MGM and S2 went upstairs to see what the commotion was and saw the Perpetrator straddled across his mother on the bed repeatedly stabbing her with the knife. MGM and S2 pulled the Perpetrator off his mother but in doing so S2 was also stabbed by the knife.

MGM called the police who attended very quickly together with the ambulance service and the Victim was found collapsed in the hallway, lifeless and unresponsive. The Perpetrator was found outside the house and he was arrested.

A post mortem was later performed by a Home Office Forensic Pathologist who found the Victim had been stabbed multiple times and had died from one of the stab wounds.

The Perpetrator was charged with the murder of his mother on 31st January 2014 and was remanded in custody and detained in a secure hospital awaiting appearance at the Crown Court as well as being assessed under the Mental Health Act 1983. He appeared at

Birmingham Crown Court on 13th February 2015 and pleaded guilty to Manslaughter on the grounds of diminished responsibility. This was accepted by the Court and he was made subject to a Hospital Order.

Analysis and Recommendations

At a panel meeting on 17th November 2014, the Overview Author brought the panel up to date with the review process and the fact that H1 had been seen together with S1 and S2 at home. The panel were concerned about S2's future and wellbeing and as a result the police representative on the panel made a referral to Children's Social Care for them to assess whether S2 had any safeguarding needs. As there was insufficient to justify either a Child in Need or a Child Protection enquiry, it has been agreed between Children's Social Care and the family that there will be an annual contact with the family on the basis of offering any support for S2 that the family may wish to take advantage of.

It is recorded that MGM told her GP that the family were using homeopathic medicine and despite the GP surgery sending vaccination reminders during 2007, 2008, 2009 for diphtheria and other immunisations the Perpetrator none of the appointment were kept.

At the time of the Perpetrators birth, 1991, there were no protocols in existence in relation to Health Agencies actively pursuing patients in relation to the possibility of domestic abuse within their relationships, so the question of domestic abuse in the Victim's life at that time was not raised. There is no evidence to suggest that there was any domestic abuse between the Victim and H1 or anyone else in the family setting.

Since 1991 there has been considerable advancement in relation to a proactive approach across health and every other agency in recognising the signs and symptoms of domestic abuse and actively broaching the subject with patients.

It may be considered however, that the mother's decision to choose not to allow the operation to correct the Perpetrator's kidney problems when he was young was a missed opportunity for professionals to consider if child at that time, or at any future time, was being put at risk.

The Perpetrator had unmet medical needs, which may have put him at risk of significant harm as a result of choices made by his mother. He was under the radar of medical attention between 1995 and 1998 during which time his health issues were not attended to by any medical professional.

Having identified the possibility of a missed opportunity, one has to consider the culture of the health service in 1991 and ask the question, "Would there have been, in reality, a challenge based on the possibility of safeguarding principles, to the parent who declines the offer of an operation?" It is suggested the answer to that question would be no.

Looking at the family's situation with the knowledge and experience of 2015 and its current legislation, one might conclude that not going through with the operation, making no referrals regarding his poor eyesight, failing to seek medical support and assistance, would now in 2015, possibly constitute a risk of significant harm to a child, but in 1991 and for a few years after that, the situation was very different.

There is no doubt that the Victim herself was of a very strong character, determined and settled in her views and was unshakeable in relation to the opinions she had formed regarding the health service and medical professionals.

There is evidence that the Victim's Father (MGF) and husband (H1) support the views of the Victim that the Health Authority had been neglectful in the care provided by the GP and also at the birth of the Perpetrator, S2 and S3.

Safeguarding concerns ought to have been identified at the time of the complications arising at the home birth of S2 and S3, when the midwife, being so concerned, rang for the assistance of an ambulance. Had the midwife not sought emergency assistance, then the lives of S2 and S3 would have been significantly at risk. It may be considered that the ongoing safeguarding concerns for S2 after the death of S3 should have been investigated. However one has to consider the culture of the health service at that time and ask the question, "Would there have been, in reality, a challenge based on the possibility of safeguarding principles, to the parent who declines emergency assistance?" The answer then was probably no, but today the answer would be yes.

In relation to the deteriorating mental condition of the Perpetrator, there is evidence to show that in the weeks leading up to the Victim's death he was behaving strangely and becoming more aggressive He assaulted his mother the day before her death. There is nothing to show that the family had any plan whatsoever to cater for what must have been an obvious deterioration in his mental stability. The family will say that the events were a family matter and they were content to deal with them within the family. Had they considered for one moment that things would escalate as they did, they say, of course they would have sought medical assistance.

The assault on his mother and his comments that he hated her could have escalated concerns within the family that the Victim was at risk at the hands of her son, but they considered this was the behaviour of a young man who was ill and, importantly, had the support of his family around him.

Following the referral by West Mercia Police to WHASCAS when the Perpetrator was found at 0300 hours, attempts were made to speak to him but the Customer Advisor for WHASCAS spoke to the Victim and not the Perpetrator. It is considered that this matter should have been escalated to a manager for a decision as to whether the matter was pursued to the degree of speaking to the Perpetrator or left as it was, being satisfied with the explanation given by his mother. In the case of a child this would normally be accepted but this referral was in respect of an adult who clearly had some problems that caused enough concern for the Police to make a referral.

In relation to Elective Home Education and its processes, there is a lack of understanding from agencies of the powers available to monitor children undertaking EHE. A similar comment has been made in a Significant Incident Learning Process (SILP) Review[3] for Worcester Safeguarding Children's Board. As a result of this SILP Review, the Independent Chair of Worcestershire Safeguarding Children Board wrote to the Parliamentary under Secretary of State for Children and Families expressing views about similar issues that have arisen during this review.

The reply to the letter from the Independent Education and Boarding Team was that in view of a number of complaints the Government has received from Local Authorities, the Department is meeting some local authority groups. Copies of both letters are attached as an appendix.

[3] Case Review 8 – Worcester Safeguarding Children's Board – SILP Review – September 2014 page 4

In view of the Government's stated intent to address the issues which are clearly of concern in more than one Local Authority, and to add weight to the urgency to see change, a recommendation is made for an additional contact with the necessary Government Department to be made.

Guidance and legislation regarding EHE states that whilst there are no duties placed upon Local Authorities to see the child for the purpose of monitoring EHE, the EHE Officer will make every effort to do so; however, where this is not possible the EHE Officer cannot enforce this.

S3.6[4] states where a parent elects not to allow access to their home or their child, this does not of itself constitute a ground for concern about the education provision being made. Where local authorities are not able to visit homes, they should, in the vast majority of cases, be able to discuss and evaluate the parents' educational provision by alternative means. If they choose not to meet, parents may be asked to provide evidence that they are providing a suitable education.

It is also important to recognise that EHE Officers do not have powers to investigate safeguarding concerns and such concerns must be investigated by those who have the appropriate authority to do so. Any and all professionals working with a home educated child should undertake their responsibilities to familiarise themselves with current home education law to avoid practice based on assumption. There is information regarding EHE available nationally, and from within the County Council, as the EHE Officer is available through the usual means of communication and is very accessible. Training opportunities are provided by the EHE Service and will continue to be provided.

The EHE Officer who came to post in 2007 recognised that home education may place some children at greater risk; however, the EHE Officer cannot make such a judgment as every parent, unless there is an Order in place denying them that right, has the right to home educate. Also, the EHE Officer does not hold risk assessment information about children.

A repeated concern rose by this and the SILP Review were regarding the EHE Officer's 'professional curiosity'. However, in accordance with guidelines, legislation and local policy in both cases, it is the view of the IMR Author for Education that the professional curiosity shown was appropriate to the information available at the time.

During the course of this Review, it has become clear that the Perpetrator's family demonstrated some degree of 'disguised compliance': when the Perpetrator was found wandering alone firstly late at night, then later at the side of a major roadway. On both occasions the Victim was spoken to and assured the Officers that she would take advantage of the advice and services being offered, but none of the services were accessed and even after numerous calls by Adult Social Care attempting to speak to the Perpetrator, the Victim said that she would pass on the details for him to contact the service as and when he felt necessary.

In April 2014, West Mercia Inter-Agency Child Protection Procedures introduced a new Chapter entitled 'Working with Hostile, Non-Compliant Clients and those who use Disguised Compliance'. This Chapter sets out procedures for professionals to deal with parents who are difficult with regard to the way they respond to professionals and the advice and

[4] DfE EHE Guidelines for Local Authorities 2013

guidance the parents receive. This guidance relates to Children and Child Protection, and it is recommended that Worcestershire Safeguarding Adult Board should consider creating similar guidance when working with adult children and their parents. It is acknowledged that when working with families that appear to have disengaged can be extremely challenging for professionals. Where possible offers of support should be made and alternative support services should be considered.

The Victim chose to move away from the services of GPs and almost all other health services. The fact remains that at this time the Perpetrator had a significant history of medical needs and moving away from the GP's list meant that he was not registered and his continuity of medical needs was broken. He fell under the radar of medical services as a child which may have put him at risk. There was no follow up from the surgery he had left regarding any other surgery he may have registered with.

Changes to agency systems

It should be noted that in February 2014 NICE issued guidance[5] entitled "Domestic Violence and Abuse: how health services, social care and the organisations they work with can respond effectively'.

This guidance has been acted upon in Worcestershire and many of the recommendations are being progressed in partnership. An extensive programme of training and awareness rising is being done across health including inputs to Doctors, GP's, A&E professionals, Midwives, Specialist Cancer Teams, Consultants and Physiotherapists.

As part of this work they have undertaken a pilot within the main Worcestershire hospital with the co-location of a Specialist Independent Domestic Abuse Advisor, (IDVA) who works across the hospital but with an emphasis of working within A&E, midwifery and alongside mental health professionals.

In addition the Worcestershire Forum against Domestic Abuse and Sexual Violence has worked with the hospital on a number of campaigns and conferences at the hospital and, most recently, the Hospitals across Worcestershire were fully engaged in the White Ribbon campaign during the International 16 days of action.

The Forum has also worked alongside the Local Safeguarding Children's Board and Worcestershire Safeguarding Adult Board and domestic abuse e-learning is freely available to all health professionals as a part of their ongoing professional development.

It should be acknowledged that much work has been done to raise awareness of the specialist domestic abuse services across Worcestershire during the last two years and demand as a result of this, has at times increased by some 79%. Specialist resources have been developed with the involvement of survivors and these are widely available across the county and promoted through the media.

West Mercia and Warwickshire Police have now begun a process of implementation of Multi-Agency Safeguarding Hubs (MASH) across the two forces areas, where referrals, information and intelligence is shared between agencies immediately, risk identified, assessed and managed.

[5] Domestic Violence and Abuse: how health services, social care and the organisations they work with can respond effectively - NICE February 2014

In 2013 a Domestic Homicide Near Miss Review was undertaken by Worcestershire Domestic Violence forum following the attempted murder of a pregnant woman.

An action from this review was to strengthen the questioning of pregnant women, by midwives, in relation to whether the women had experienced any Domestic Abuse from either their current or past partners. This continues to be an operational guideline within the Trust.

There has been a programme of training during 2014 to raise awareness of Domestic Abuse within the Trust's Maternity Services and also Emergency Departments. There is also a pilot project currently running whereby an Independent Domestic Violence Advocate (IDVA) is operating on a part time basis from one of the hospital Emergency Departments. The IDVA will also become involved with any cases referred by staff from other relevant areas of The Trust.

The Trust has a lead midwife for Domestic Abuse and also a senior nurse within the Emergency Department, who has a specific interest in and involvement with the pilot project for Domestic Abuse. The Trust also has representation on the local Multi Agency Risk Assessment Conference (MARAC).

Conclusions

The Victim was killed by her middle son in the most tragic of circumstances. The incident was witnessed by the Victim's Mother and youngest son, who was also injured in the stabbing incident.

From the information gathered by IMR Authors, there is evidence that the Perpetrator had significant health problems at birth, which medical opinion was then and is now, that a routine operation would have cured his symptoms. The family state that they were told that there was a possibility that the Perpetrator would not live passed primary school age, but this was denied by health professionals and found to be unsubstantiated by an Independent Convenor at a later investigation but that is the view of the family.

It appears that medication given to the Perpetrator during his early years could have had an effect on his hearing, but that may have been a choice of treating his reflux condition against the possible damage to hearing. In any event later examination of his hearing showed no ill effects. However, his eye sight deteriorated as he grew older but his Mother, the Victim, declined to seek medical advice or treatment for him, which it is thought was to the detriment of his health.

Mention has been made by family members of the choices the Perpetrator was entitled to make as he became an adult regarding his, medical treatment, but concerns are expressed about those decisions made by the Victim when the Perpetrator was a child. During that period of time, the Victim had a duty care for him, and medical evidence suggests that her decisions put the child at risk of harm by not attending to his medical needs. Records show that at 4 years of age the Perpetrator was not toilet trained, he had long standing renal problems, he had speech and language delays, he was emotionally insecure and he had difficulty separating from his mother.

There followed some years where the Victim was extremely protective of the Perpetrator to the extent that he made the comment to the Police post incident that he could never live a life of his own. The Perpetrator tried Regression Therapy and a variety of alternative treatments, some of which appeared quite unusual. There is no doubt that his health

problems in later life could have been treated when he was a child and by choosing a less traditional medical treatment and favouring a more unusual alternatives that did not seem to cure him, could now be considered abusive behaviour.

The Perpetrator, his older brother and younger brother all received (and the younger brother is still receiving) Elective Home Education, which, as stated above has concerns in terms of supervision of the student. Considering that this whole family were outside any contact with any agency other than EHE, it was an opportunity missed for the only professional involved with the family to make an assessment of all three boys' welfare.

As stated, during the process of this review the Panel, being concerned by the facts reported, made a referral to Children's Social Care in respect of S2. The outcome was a decline of the offer of assistance by H1 but an agreement that an annual visit would be made by Children's Social Care regarding the safeguarding of S2.

The Panel are satisfied that there were opportunities for the Victim to do something about her son's medical problems both in his formative years as a child, and in his later years as an adult. The situation became more difficult as the Perpetrator grew into a teenager and adult and was able to make his own decision about his medical treatment. The family will say he could not lead a totally independent life due to his eye sight problems.

There is evidence to show that the Perpetrator's mental illness manifested itself very quickly, indeed the family will say, within a matter of weeks. His behaviour was strange and aggressive. He assaulted his mother the day before her death, but the family were content to deal with that. The family appreciated that the Perpetrator needed some mental health assistance. It was the evening before the Victim's death that his grandparents were en-route to a mental health hospital.

There is no doubt that the attack on his mother was so quick and sudden that no one could have predicted it occurring, or indeed done anything to prevent it.

List of recommendations

Recommendation No 1

The Chair of the Safer Community Partnership writes to Minister for Education expressing continuing concerns that the guidance for Elective Home Education is not fit for purpose and requires an urgent review by the Department of Education to ensure that a more positive supervision and monitoring policy is introduced.

Recommendation No 2

All agencies to ensure that all front line professionals are aware of the West Mercia Inter-Agency Child Protection Procedures especially the Chapter adopted in April 2014, 'Working with Hostile .Non-Compliant Clients and those who use Disguised Compliance'.

Recommendation No 3

Worcestershire Safeguarding Adult Board to consider formulating guidance similar to West Mercia Inter-Agency Child Protection Procedures 'Working with Hostile, Non-Compliant Clients and those who use Disguised Compliance' when works with adult children and their parents.

Recommendation No 4

NHS England will alert GPs locally to ensure any non-attendance of appointments are robustly followed up through the organisations 'Did Not Attend/Was not brought Policy ' . GPs should ensure their Practice has a documented process in place to liaise with HV/SN's about transfers in or out of their Practice of children where there are safeguarding concerns.

Recommendation No 5

NHS England will raise the issue of 'de-registration' at a national level as it pertains to the wider national patient records system with a recommendation to work towards an electronic solution of monitoring of de-registration.

Appendix A

Terms of Reference

The Domestic Violence Crimes and Victims Act 2004 Section 9 (3), which was implemented with due guidance[6] on 13th April 2011, (amended in 2013) establishes the statutory basis for a Domestic Homicide Review.

Under this section a 'Domestic Homicide Review' means a review of the circumstances in which the death of a person age 16 or over has, or appears to have, resulted from violence, abuse or neglect by –

(a) A person to whom he was related or with whom he was or had been in an intimate personal relationship, or
(b) a member of the same household as himself, held with a view to identifying the lessons to be learnt from the death

In compliance with the Home Office Guidance, [7] West Mercia Police notified the circumstances of the death in writing to the Community Safety Partnership (CSP) for Worcestershire. The CSP accordingly notified the Home Office of the circumstances.

The Domestic Homicide Review Panel

The review was carried out by a Domestic Homicide Review Panel made up of representatives of agencies who were involved in delivering services to the family of the victim. It included senior officers of agencies that were involved. The professional designations of the panel members were:

- Strategic Coordinator for Domestic Abuse and Sexual Violence, Worcestershire County Council
- West Mercia Police
- National Probation Service West Mercia
- Designated Nurse for Safeguarding
- Wychavon Community Safety Manager
- Worcestershire County Council Quality & Safeguarding Services Manager
- County Council Safeguarding Children's Social Care
- Worcestershire County Council Health & Wellbeing (Administrator)

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Home Office Guidance[8] requires that;

[6] Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews – Home Office 2011 *www.homeoffice.gov.uk/publications/crime/DHR-guidance*
[7] Home Office Guidance page 8
[8] Home Office Guidance 2013 page 11

> *"The Review Panel should appoint an independent Chair of the Panel who is responsible for managing and coordinating the review process and for producing the final Overview Report based on IMRS and any other evidence the Review Panel decides is relevant", and "…The Review Panel Chair should, where possible, be an experienced individual who is not directly associated with any of the agencies involved in the review."*

The panel chair and the overview report writer was Mr Malcolm Ross, a retired Senior Detective from West Midlands Police. He has 25 years' experience in conducting case reviews for local authorities in the United Kingdom and is independent of any agency involved in this case.

Time Period

It was decided that the review should focus on the period from 1st December 1990 (Pre-birth of the Perpetrator) to the date of the Victim's death on 30th January 2014, with an exception for agencies as per para 1.8.2. below.

Scoping the review

The process began with a scoping exercise by the panel to identify agencies that had involvement with the Victim and Perpetrator prior to the homicide. Where there was no involvement or significant involvement by agencies the panel were advised accordingly.

Agencies were asked to identify any other significant information that may add to an understanding of the quality of dynamics of the relationships within the family before and after the time period.

The purpose of the extended period is to examine and identify what opportunities were available for agencies to intervene or challenge decisions that were made in respect of the Perpetrator and siblings by parents where concerns may have been escalated by agencies.

Individual Management Reviews

The following agencies were requested to prepare chronologies of their involvement with the Victim and her family, carry out individual management reviews and produce reports.

- West Mercia Police
- Health Trusts– including Birmingham Children's Hospital, Worcestershire Acute Hospital Trust, Warwickshire Health and Care Trust, & NHS England
- Education – to include River School (Independent Christian School), WCC Home Education, Parent Partnership Services
- Adult Social Care
- Children's Social Care
- Quantum Healing Hypnosis Therapy

Terms of Reference

The Terms of Reference for this DHR are divided into two categories i.e.:

- the generic questions that must be clearly addressed in all IMRs; and
- specific questions which need only be answered by the agency to which they are directed.

The generic questions are as follows:

1. Were practitioners sensitive to the needs of the victim and the perpetrator, knowledgeable about potential indicators of domestic abuse and aware of what to do if they had concerns about a victim or perpetrator?
2. Was it reasonable to expect them, given their level of training and knowledge, to fulfil these expectations?
3. Did the agency have policies and procedures for risk assessment and risk management for domestic abuse victims or perpetrators (DASH) and were those assessments correctly used in the case of this victim/perpetrator?
4. Did the agency have policies and procedures in place for dealing with concerns about domestic abuse?
5. Were these assessments tools, procedures and policies professionally accepted as being effective? Was the victim subject to a MARAC?
6. Did the agency comply with domestic abuse protocols agreed with other agencies, including any information sharing protocols?
7. What were the key points or opportunities for assessment and decision making in this case?
8. Do assessments and decisions appear to have been reached in an informed and professional way?
9. Did actions or risk management plans fit with the assessment and the decisions made?
10. Were appropriate services offered or provided, or relevant enquiries made in the light of the assessments, given what was known or what should have been known at the time?
11. When, and in what way, were the victim's wishes and feelings ascertained and considered?
12. Is it reasonable to assume that the wishes of the victim should have been known?
13. Was the victim informed of options/choices to make informed decisions?
14. Were they signposted to other agencies?
15. Was anything known about the perpetrator? For example, were they being managed under MAPPA?
16. Had the victim disclosed to anyone and if so, was the response appropriate?
17. Was this information recorded and shared, where appropriate?
18. Were procedures sensitive to the ethnic, cultural, linguistic and religious identities of the victim, the perpetrator and their families?
19. Was consideration for vulnerability and disability necessary?
20. Were Senior Managers or agencies and professionals involved at the appropriate points?
21. Are there other questions that may be appropriate and could add to the content of the case? For example, was the domestic homicide the only one that had been committed in this area for a number of years?
22. Are there ways of working effectively that could be passed on to other organisations or individuals?
23. Are there lessons to be learnt from this case relating to the way in which this agency works to safeguard victims and promote their welfare, or the way it identifies, assesses and manages the risks posed by perpetrators? Where could practice be improved? Are there implications for ways of working, training, management and supervision, working in partnership with other agencies and resources?

24. How accessible were the services for the victim and the perpetrator?
25. To what degree could the homicide have been accurately predicted and prevented?

In addition to the above, the following agencies are asked to respond specifically to individual questions:

- If the organisation that was providing Regression Therapy to the Perpetrator can be identified, a request to be made for an Individual Management Review/Report.
- Health and Education: Why did the family disengage with statutory agencies and what efforts were made to ensure the children's well-being and safeguarding was being considered (It is the families' view that this point should read "Why did the family seek alternative services from statutory agencies?").
- Police, Mental Health and Adult Social Care: Were there any reasons to doubt the Perpetrator's mental capacity in relation to decisions being made?

Individual Needs

Home Office Guidance[9] requires consideration of individual needs and specifically:

- "Were procedures sensitive to the ethnic, cultural, linguistic and religious identity of the Victim, the Perpetrator and their families? Was consideration for vulnerability and disability necessary?"

Section 149 of the Equality Act 2010 introduced a public sector duty which is incumbent upon all organisations participating in this review, namely to:

- Eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under this Act;

- Advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it;

- Foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

The review gave due consideration to all of the Protected Characteristics under the Act.

The Protected Characteristics are: age, disability, gender reassignment, marriage and civil partnerships, pregnancy and maternity, race, religion or belief, sex and sexual orientation.

Lessons Learned

The Review will take into account any lessons learned from previous Domestic Homicide Reviews as well as Children and Adult Serious Case Reviews and appropriate and relevant research.

[9] Home Office Guidance page 25

Media

All media interest at any time during this review process will be directed to and dealt with by the Chair of the South Worcestershire Community Safety Board.

Family Involvement

Home Office Guidance[10] requires that:

> "members of informal support networks, such as friends, family members and colleagues may have detailed knowledge about the victim's experiences. The Review Panel should carefully consider the potential benefits gained by including such individuals from both the victim and perpetrator's networks in the review process. Members of these support networks should be given every opportunity to contribute unless there are exceptional circumstances",
> and:
> "Consideration should also be given at an early stage to working with family liaison officers and Senior Investigating Officers (SIOs) involved in any related police investigation to identify any existing advocates and the position of the family in relation to coming to terms with the homicide."

The views of the family members and were taken into consideration. The family members were invited to participate in the review process.

[10] Home Office Guidance page 15