WINCHESTER COMMUNITY SAFETY PARTNERSHIP

DOMESTIC HOMICIDE REVIEW

Executive Summary

Isobel – July 2019

Author – Graham Bartlett

Review Completed: 20th June 2021

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1 INTRODUCTION

1.1 This report of a domestic homicide review examines agency responses and support given to Isobel, a 50-year-old British woman, prior to her death in July 2019 following injuries she suffered at her home on that day.

1.2 In addition to agency involvement, the review examines the past to identify any relevant background or trail of abuse before the homicide, whether support was accessed within the community and whether there were any barriers to accessing support. By taking a holistic approach, the review seeks to identify appropriate solutions to make similar tragedies less likely.

1.3 The subjects of the review are[1]:

Victim	**Name**	Isobel
	DOB	October 1968
	DOD	July 2019
	Address	Hampshire

Perpetrator	**Name**	Sam (Not their birth name) - Deceased
	Age at time of Homicide	17 years
	Address	Hampshire (with mother) and Barnsley (with father)
	Relationship to Victim	Adolescent child
	Charge(s)	Was awaiting trial for murder when they died.

Others

Name	**DOB**	**Relationship to Victim/Suspect**
Paul	1968	Ex-husband of victim and father of suspect
Will	2007	Son of victim and brother of suspect
Jane	1990	Step mother of suspect

1.4 The review considered agencies' contact and involvement with Isobel, Sam, Paul, Will and Jane between 1st July 2016 and 1st July 2019 to reflect what was known regarding agency contact with the family. There had been no reports, to any agency, of domestic violence or abuse prior to or within this period.

1.5 On 16th July 2019, the Winchester Community Safety Partnership (CSP) decided, based on the police referral dated 2nd July 2019, that the criteria for a domestic homicide review were met. Consequently, they commissioned this review.

[1] Anonymised names - all names of parties subject to the review and those connected with them are pseudonyms and were agreed with family members

2 TERMS OF REFERENCE

2.1 The specific terms of reference for this domestic homicide review were agreed as follows:

1. Whilst Isobel had no known contact with any specialist domestic abuse agencies or services, the DHR will review whether there was any history of domestic abuse involving her, Paul, Will, Jane or the perpetrator and assess whether there were any warning signs of escalation or vulnerability.
2. Whether there were opportunities for agency intervention in relation to domestic abuse involving Isobel, Paul, Will, Jane and the perpetrator that were missed or could have been improved.
3. Whether there were opportunities for professionals to 'routinely enquire' as to any domestic abuse involving the victim, Paul, Will, Jane or the perpetrator that were missed.
4. Whether there were opportunities for professionals to refer any reports to other agencies of domestic abuse towards the victim, Paul, Jane or Will by the perpetrator and whether those opportunities were taken.
5. Whether the services being accessed by the perpetrator during the time period under review were sufficiently aware of any risk they might present, how that risk was managed and whether any concerns and/or risk management plans were effectively shared between services and between Barnsley and Hampshire based agencies.
6. Whether there were any other opportunities to assess the risk the perpetrator might present to any members of their family and if so whether those opportunities were taken. This will include reviewing the quality of those risk assessments and whether they met the threshold for referral into Multi Agency Risk Assessment Conference (MARAC).
7. Whether there were any barriers or disincentives experienced or perceived by Isobel or her family/ friends/ colleagues in reporting any abuse including whether they knew how to report domestic abuse and whether they knew what the outcomes of such reporting might be.
8. Whether family, friends, employers or colleagues were aware – by any means - of any abusive or violent behaviour from the perpetrator prior to the homicide and what they did or did not do as a consequence.
9. Whether more could be done in the locality to raise awareness or accessibility of services available to victims of domestic violence, their families, friends or perpetrators.
10. Whether Isobel's, Paul's or Jane's previous experience of services may have had an impact on their likelihood of seeking support during the period under review.

In addition:

- The review will consider any equality and diversity issues that appear pertinent to the victim, perpetrator and dependent children e.g. age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex and sexual orientation.
- The review will identify any training or awareness raising requirements that are necessary to ensure a greater knowledge and understanding of domestic abuse processes and / or services in the Winchester City Council area.

3 CONTRIBUTORS TO THE REVIEW

3.1 Initially, the following agencies were required to submit Summaries of Involvement to allow the panel an opportunity to understand the nature and scope of their involvement with any of the parties to the review during the time period under review.

- Barnsley Education Provider
- Barnsley Council/CSP
- Basingstoke CSP
- Hampshire School
- Hampshire Constabulary
- Hampshire County Council – Children's Services, Education, Adult Social Care and Health
- Hampshire Hospitals NHS Trusts
- Southern Health Tier 4 Mental Health Inpatient Unit
- Portsmouth Hospitals NHS Foundation Trust
- Primary Care – GP surgeries
- Priory Group Limited
- National Probation Service
- South Central Ambulance Service
- South Yorkshire Police
- South West Yorkshire Partnership NHS Foundation Trust
- Sussex Partnership NHS Foundation Trust
- A Young People Wellbeing Centre
- Trinity Winchester Women's Service
- West Hampshire Clinical Commissioning Group
- Winchester City Council - Supporting Families, Homelessness, Community Safety, Housing Services, Revenue and Benefits

3.2 Having reviewed the Summaries of Involvement, at the initial panel meeting on the 5th September 2019 the following agencies were required to submit IMRs and Chronologies:

- Barnsley Education Provider
- Hampshire School
- Hampshire County Council Children's Services
- Hampshire County Council Education Services
- Huddersfield Road Surgery
- Southern Health Tier 4 Mental Health Inpatient Unit
- Portsmouth Hospitals NHS Trust
- Priory Group Limited

- South Central Ambulance Service NHS
- South West Yorkshire Partnership NHS Foundation Trust
- Sussex Partnership NHS Foundation Trust
- A Young People Wellbeing Centre
- Wickham Surgery

Each of those agencies were required to:

- Provide a chronology of their involvement with the subjects of the review during the relevant time period using the provided template.
- Search all their records outside the identified time periods to ensure no relevant information was omitted.
- Provide an Individual Management Review (IMR): identifying the facts of their involvement with the subjects of the review critically analysing the service they provided in line with the specific terms of reference; identifying any recommendations for practice or policy in relation to their agency. Agencies were provided with an IMR template and asked to confirm the independence of the IMR authors.

4 THE REVIEW PANEL

4.1 Mr Graham Bartlett was appointed to chair the Domestic Homicide Review panel and be the author for this review. He is the Director of South Downs Leadership and Management Services Ltd. He Independently Chairs the East Sussex and Brighton and Hove Safeguarding Adults Boards and, until recently, was the Independent Chair of Brighton and Hove Local Safeguarding Children Board. He has completed the Home Office on line training for independent chairs of Domestic Homicide Reviews and the Social Care Institute for Excellence Learning Together Foundation Course. He has experience of chairing and writing numerous Domestic Homicide Reviews, Serious Case Reviews and Safeguarding Adults Multi agency reviews. He is a retired Chief Superintendent from Sussex Police latterly as the Divisional Commander for Brighton and Hove. He had previously been the Detective Superintendent for Public Protection which entailed being the senior officer responsible for the Force's approach to Child Protection, Domestic Abuse, Multi Agency Public Protection Arrangements (MAPPA), Missing Persons, Hate Crime, Vulnerable Adults and Sexual Offences. He retired in March 2013. He had no involvement or responsibility for any policing in Hampshire or the Isle of Wight nor any connection with Winchester Community Safety Partnership.

4.2 The panel comprised the following members:

- Graham Bartlett – Independent Chair
- Carol Morgan - Specialist Adviser for Safeguarding Adults, South West Yorkshire Partnership NHS Foundation Trust (SWYPFT)
- Carmain Gibson-Holmes – General Manger for Wakefield CAMHS, South West Yorkshire Partnership NHS Foundation Trust
- Julie Warren-Sykes - Associate Director of Nursing, Quality and Professions, South West Yorkshire Partnership NHS Foundation Trust
- Noel Devine - Lead Serious Incident Investigator, South West Yorkshire Partnership NHS Foundation Trust

- Dee John – Head of Service (Hampshire Achieves) Skills & Participation, Hampshire County Council Children's Services
- Julie Yalden - Named/Lead Nurse for Safeguarding Children Hampshire CAMHS Sussex Partnership Foundation NHS Trust
- Bryan Lynch - Director of Social Work & Trust lead for DHRs, Sussex Partnership Foundation NHS Trust
- Wanda Reynolds - Hampshire CAMHS General Manager, Sussex Partnership Foundation NHS Trust
- Michaela Whitaker - Havant CAMHS Team Manager, Sussex Partnership Foundation NHS Trust
- Michele Ennis - Adult Safeguarding & Quality Nurse West Hampshire Clinical Commissioning Group
- Rachel Windebank – Operations Director, Stop Domestic Abuse
- Colin Mathews – Serious Case Reviewer, Hampshire Constabulary
- Chris O'Dea - Specialist Nurse Safeguarding Children, Southern Health NHS Foundation Trust
- Rebecca Lloyd - Specialist Nurse Safeguarding Children, Southern Health NHS Foundation Trust
- Ian Fisher - Safeguarding Specialist Nurse, Southern Health NHS Foundation Trust
- Paul Phillips - Safeguarding Manager, South Central Ambulance Service NHS Foundation Trust
- Sandra Tuddenham – Neighbourhood Services and Community Safety Manager, Winchester City Council
- Sue McKenna – Chief Executive, Trinity Winchester
- Tonia Redvers - Head of Hidden Violence and Abuse and Counselling Services, You Trust

4.3 The panel met on three occasions, and received five drafts of the report to review.

4.4 Whilst all represent their own agencies, none were directly involved in the services provided or the supervision on those providing services to any of the subjects of the review.

4.5 There was no specialist organisation invited to the review however it has been noted for future reference that there are benefits to having a specialist agency advising the review panel.

5 BACKGROUND INFORMATION

5.1 Isobel married Paul in September 1999. After they lived in Birmingham and Basingstoke, they settled in the Waterlooville area until they separated in 2011.

5.2 Sam was born in 2002 and through their teens, struggled with their gender identity and, when they turned 16, they changed their name by deed poll to Sam as this was gender-neutral.

5.3 Will was born in 2007 and some family members say the two siblings did not always get on.

5.4 Isobel and Paul divorced around 2012, at which point Isobel bought her home where she lived with Sam and Will until her death. The divorce was acrimonious and the Review was told by Isobel's sister that she suspected economic abuse as a result of friction regarding maintenance and child access. This was an impression she had, the detail of which she did not know.

5.5 In April 2017, Isobel's brother died as a result of suicide abroad, where he lived with his wife. This was absolutely devastating for the whole family and Isobel was treated for depression, such was her shock and grief. The following month Sam was admitted to hospital having tried to take their own life by hanging, drinking bleach and taking tablets. There was some indication that they had been bullied at The Hampshire School – although it seems they did not tell the school or their mother about this.

5.6 Upon release from the acute hospital, Sam was admitted to the Priory Hospital and, as a result, missed the summer term at school, not returning until September 2017. The following year Sam did well in their GCSEs.

5.7 On Sam's 16th birthday, they changed their name by deed poll. On moving up to Year 12, Sam seemed to struggle with the leap to A level studies. In the years leading up to Isobel's death, Sam became 'Goth-like' - dyed their hair black, wore only black clothes and would never go out in the sun, so appeared very pale skinned.

5.8 While Sam's attempt to take their own life had a huge impact on their mother, her family say she was never worried about her own safety from them; she was simply worried about Sam trying to take their own life again.

5.9 In the autumn of 2018, Isobel found Sam on the floor at home and they told her they were feeling dangerously suicidal. On this occasion they were taken to hospital, then to the Southern Health Tier 4 Mental Health General Adolescent Inpatient Unit in Winchester. Sam told Isobel they did not like The Unit as they were unable to deal with their gender neutrality.

5.10 Upon leaving The Unit in January 2019, Sam went to live with Paul in Barnsley and enrolled in a Sixth Form College in that area.

5.11 In April 2019 Isobel's family went on holiday to Scotland and Isobel joined them with Sam and Will. Sam appeared to be in good spirits and was positive about life in Barnsley.

5.12 Isobel's family say that, in late May or early June 2019, she told them that Paul was having to move Sam out of his address as Jane was struggling to deal with them. Paul wanted Sam to move into a bedsit in Barnsley so that they could continue at the Sixth Form College. Isobel was very upset about this and she attended a Care Programme Approach - CPA - meeting in Barnsley the week before she died to try to sort things out. That meeting decided such a move was inappropriate. Paul said the proposed move was to do with cramped accommodation and an option was for him to move with Sam.

5.13 In late June 2019, Sam temporarily returned to stay with their mother to spend time with her and their brother to celebrate their birthday and to catch up with friends.

5.14 Police were called to Isobel's address by Sam stating that they had killed their mother. They said they had strangled her and stabbed her with knives. Police attended and Sam surrendered willingly to custody. Their mother, Isobel, was found dead in the living room. She had a laceration and bruising to her neck and multiple stab wounds to her arm.

5.15 Sam was taken into police custody where they were assessed by medical professionals and detained for further assessment under section 2 of the Mental Health Act. Whilst it was too early to make a diagnosis of their condition, there was a suspicion

that they may have been suffering from some form of psychosis.

5.16 Whilst on the phone to police, in police custody and in text messages to associates prior to their arrest, Sam made full and partial admissions to being responsible for Isobel's death.

5.17 Sam was charged with Isobel's murder but was found dead in their hospital cell in October 2020, four days before their trial.

6 FINDINGS

6.1 Over the two years preceding Isobel's death, Sam's mental health deteriorated with at least one attempt to take their own life. It seemed they were struggling with friendships and may have been bullied at school. Worryingly, a few months before their suicide attempt they referred to a 'kill list' and told a girl she was number six on it. In their suicide note they said they had killed before and had killed animals, going on to name people and groups they said had bullied them.

6.2 Professionals' predominant concern was Sam's own mental health and preventing them from self-harming. However, despite risk assessments covering harm to others, there was little evidence that Sam's motivations, objectives and intentions behind the 'kill list', their claim to have killed animals or what prompted them to say they had killed before were ever adequately explored. On admission to Queen Alexandra Hospital, they were asked about these matters but their explanations were accepted without further scrutiny.

6.3 There were significant tensions between Isobel and Paul and she said she did not feel safe with Sam at home. Both Isobel and Paul seem to regard the other of exercising control over the other and, from the information provided by her sister, Isobel may have felt she was controlled by Sam too. This did not appear to feature in any professional's assessment or consideration and, had it have done, and been explored it may have resulted in different conversations with Isobel. That said, on what she did say it seemed her worries about having Sam at home were more to do with keeping them safe from themselves.

6.4 This section will focus on the conclusions and findings, organised according to the terms of reference. Because there were so few indicators, some of the following paragraphs look at more than one of those terms of reference but all have been examined in detail.

1 Whilst Isobel had no known contact with any specialist domestic abuse agencies or services, the DHR will review whether there was any history of domestic abuse involving her, Paul, Will, Jane or the perpetrator and assess whether there were any warning signs of escalation or vulnerability.

6.5 Prior to the homicide, there was no known history of physical violence between any of the subjects of this review. The break-up of Isobel and Paul's marriage was acrimonious, but not physically violent. Equally, Sam was never known or suspected to have subjected Isobel to any form of physical threat or violence. There were occasions when their behaviour could be challenging and possibly manipulating, but the predominant risk they overtly posed was to themselves. They said, as already mentioned, they had a 'kill list,' claimed to have killed animals and asserted that they had killed two people. Had these been explored in more detail that assumption may have changed.

2 Whether there were opportunities for agency intervention in relation to domestic abuse involving Isobel, Paul, Will, Jane and the perpetrator that were missed or could have been improved.

6.6 There were no recognised domestic abuse factors involving the family, but there were suggestions that either or both Paul and Isobel may have been, subject to coercive control. The behaviours described by her sister and Paul suggests coercive control, although only articulated as such by Paul and his mother. Isobel's comments regarding family therapy, for example could have been explored deeper to understand whether she was merely uncomfortable in such surroundings or whether Paul and/ or Sam would use the sessions to control her. Likewise, Paul's views might have been considered as he felt this was one of the few places he had a voice.

6.7 Isobel's sister said that Paul would control her around child access visits and that she had to walk on eggshells with Sam. Paul said Isobel denied or changed access arrangements. Had professionals asked relevant questions when screening, assessing or when Isobel divulged concerns she may have revealed more which may have provided an opportunity for appropriate support or intervention. Likewise had professionals sought Paul's views that may have provided another perspective.

3 Whether there were opportunities for professionals to 'routinely enquire' as to any domestic abuse involving the victim, Paul, Will, Jane or the perpetrator that were missed.

6.8 Portsmouth Hospital Trust's Domestic Abuse policy highlights that suicidality and self-harm are potential indicators of domestic abuse. Furthermore, the policy highlights that the risk of experiencing domestic abuse is raised if someone is a man aged between 16 and 19, has a mental health problem, is transgender or transsexual or gay or bisexual.

6.9 It is therefore reasonable to expect that staff working with Sam in 2017 and 2018 could have discussed domestic abuse with them. The Trust say any such conversation would probably have been from a perspective of viewing them as a potential victim rather than perpetrator. However, as with all professional curiosity, it may have opened a wider discussion. That moment may not have been the most appropriate time for these conversations, as Sam was experiencing an acute mental health crisis, but every contact should be seen as a potential opportunity.

6.10 The suicide note and future discussions around the 'kill list', Sam's claim to have killed animals and to have killed others were questioned but not followed up having heard their explanation. The links between animal abuse and domestic violence are well known[2] and, while the presenting issue was self-harm, these comments should have evoked further exploration.

6.11 Portsmouth Hospital Trust's notes indicate that Isobel told CAMHS she felt unsafe at home with Sam but there is no evidence this was followed up. It is possible her feelings were around not being able to keep Sam safe from them self but that was never explored any deeper at the time. It is not unusual for victims of domestic abuse to minimise or deflect their fears and this comment should have triggered further enquiry.

6.12 CAMHS have told the review that, as a service, they regularly ask children about their home life and parental relationships. Dependent upon the response they may specifically ask about domestic abuse. As a service, routine enquiry is not always used but they say this will be picked up in safeguarding training as a recommendation going forward. They also reported that, if adults are seen alone as part of a CAMHS assessment then the nature of adult relationships is questioned and enquiry regarding domestic abuse may be made. These statements seem not to address the possibility of adolescents being abusive to parents which, given CAMHS role, must be a reality.

6.13 Paul says that Hampshire CAMHS did not speak with him, the non-residential father,

[2] https://www.nspcc.org.uk/globalassets/documents/research-reports/understanding-links-child-abuse-animal-abuse-domestic-violence.pdf

at all. He felt he had no voice in Sam's Hampshire community care and that this was a serious omission. There seems no reason why CAMHS would not have been able to speak with him and this might have provided a fuller picture of what life was like for Sam.

Recommendation 1

Sussex Partnership NHS Foundation Trust should review CAMHS engagement with non-residential parents when assessing or providing treatment to patients so as to glean a fuller understanding of their life and needs.

6.14 The Priory report that Isobel provided a report for the ADOS Assessment. In the report under the title 'relationships at home' she reports that Sam has a 'love-hate' relationship with their brother Will. She also stated that before admission Sam was very harsh, bossy and bullied Will, however since Sam's admission they had actively been trying hard to get on with their brother and their relationship is much better. This seems not to have been explored fully particularly around whether they exerted coercive control over any of their family.

6.15 Staff at the Southern Health Tier 4 Mental Health Inpatient Unit could have enquired through a number of opportunities such as, 1-1 sessions with Sam, telephone updates regarding Sam's care with their parents, during visiting times and following home leave. However, the culture appears that it is likely that if no historic issues were known or concerns raised at the time, no specific questions regarding domestic abuse would have been raised. General questions regarding behaviour and what was difficult and went well on home leave would have been but, staff should have asked specific questions relating to domestic abuse when Sam, Isobel or Paul were alone. It was very apparent that Isobel was extremely worried about safety on home visits but often this was not fully or accurately documented or explored. She had also indicated to her sister she was being controlled by Paul and Paul told the review Isobel controlled him. Had professionals taken a wider view of possible domestic abuse, this might have enabled a different conversation about where any risk actually lay.

6.16 IMR authors have reflected that the consistency and compliance of routine or targeted enquiry in health settings is not well embedded. For example, the Southern Health NHS Foundation Trust policy[3] (which applies to the Southern Health Tier 4 Mental Health Inpatient Unit) questions the efficacy of service wide routine enquiry, while the Hampshire Safeguarding Adults Board DVA Pathway[4] promotes it. Work is ongoing across Hampshire to reach a position where policies and procedures are aligned to ensure routine enquiry is carried out at every appropriate opportunity.

Recommendation 2

The Hampshire Clinical Commissioning Groups, Safeguarding Children Partnership, Safeguarding Adults Boards and health providers (whether NHS or private) should, as a matter of urgency, agree a consistent policy and practice to support routine and targeted enquiry for all forms of domestic abuse which ensures that every opportunity is taken to identify where such abuse may be being perpetrated and to signpost or offer services appropriate to need.

4 Whether there were opportunities for professionals to refer any reports to other agencies of domestic abuse towards the victim, Paul, Jane or Will by the perpetrator and whether those opportunities were taken.

[3] http://www.southernhealth.nhs.uk/_resources/assets/inline/full/0/68267.pdf
[4] https://www.hampshiresab.org.uk/wp-content/uploads/DVA-Questions-and-Pathway-FINAL-DEC-2018.pdf

6.17 Because there was no disclosure of domestic abuse involving the family, subject to the findings elsewhere, there were no missed opportunities to make onward referrals. However, had more curiosity been shown, as recommended above, opportunities may have arisen which could have been taken.

5 Whether the services being accessed by the perpetrator during the time period under review were sufficiently aware of any risk they might present, how that risk was managed and whether any concerns and/or risk management plans were effectively shared between services and between Barnsley and Hampshire based agencies.

6 Whether there were any other opportunities to assess the risk the perpetrator might present to any members of their family and if so whether those opportunities were taken. This will include reviewing the quality of those risk assessments and whether they met the threshold for referral into Multi Agency Risk Assessment Conference (MARAC).

6.18 The predominant presentation, and therefore the focus of all agencies, was on the risk Sam presented to them self. That was, of course, of the highest priority. The risk assessments exclusively graded Sam's risk to others as being either low or non-existent. This is understandable in terms of their presentation, the suicide attempts and the suicidal ideation. Sam's struggle with their gender identity as well as their autistic symptoms and depression centred on their mental health and harm towards them.

6.19 However, the 'kill list,' the reference to harming animals and killing others that were referred to during Sam's first admission to Queen Alexandra Hospital and, periodically, onwards appear to have dropped off the radar.

6.20 The Priory CPA minutes have recorded that Sam did have individuals they wished to target but the medical team appeared to have further explored this with Sam and concluded it was now regarded as an idea which Sam was no longer holding onto.

6.21 The 'kill list' is then notionally referred to from time to time in the notes of the various health providers but the review did not get a sense of anyone trying to understand what lay behind them. Sam's initial explanations appear to have been accepted. Whether the aspects of the risk assessments perpetuated this assumption is not known but, to fully understand the breadth of any risk Sam may present, these 'indications' of wishing to cause or having caused harm to others should have been robustly assessed.

6.22 Following Sam's admission to The Priory they presented as having made a good recovery. The minutes dated 31 May 2017 state 'When questioned about being bullied and the list of people Sam had to target, they now think this is a silly idea and doesn't appear to be holding onto it. The question is how would Sam manage when back in the school environment?'

6.23 During The Priory admission, Sam appeared to engage positively with both staff and peers with no incidents of violence and aggression. Earlier risk assessments completed by Hampshire CAMHS, however, assessed Sam as presenting with a risk of aggression and violence with a difficulty controlling their temper. The assessments also noted a lack of positive contacts and disrupted relationships. There appeared to be no management plan to mitigate this risk.

6.24 Later CAMHS risk assessments noted these risks to have dissipated, although in July 2018 there was reference to sibling rivalry and having little in common with Will due to their age differences. The same assessment stated there was no violence and aggression although temper control was unknown.

6.25 It is unlikely that Sam had killed before but to document that they had and had an intent to, may have been indicative of an underlying ideation. Aggression, control and temper are terms that continued to surface during Sam's in-patient care and this review

remains unconvinced that these factors, coupled with Isobel's expressed fear of Sam being at home were ever effectively considered in terms of their risk to family members. The evidence seen provides no reassurance that these were examined in the round with a 'worst case scenario' in mind.

Recommendation 3

Where possible, health providers health providers involved in this review should assure themselves that in assessing risk to others, their tools and practices embrace all assessments, presentations, ideations and views of third parties to triangulate any expressed or reported risk so as to effectively establish the risk level and the management plan aimed to reduce it.

6.26 The information sharing between all services, except for the Hampshire school not sending the full safeguarding file to Barnsley, and the initial acute hospital admission not being referred to CSD was good. With the above caveat, the risk assessments were shared appropriately. There was nothing in South Yorkshire CAMHS observations at the CPA two days before Isobel's death to raise any concerns as to her safety should Sam stay with her in Hampshire.

6.27 The families remain concerned that the outcome of the Priory ADOS assessment was never documented and therefore they and Sam had no clarity whether they did or did not have an ASD. This was only clarified after Isobel's death, while Sam was detained. It seems unusual to not communicate the outcome of assessments with young people and families nor in discharge summaries. There has been no cogent explanation as to why this was the case.

Recommendation 4

Priory Hospitals review how it assesses, diagnoses and communicated ADOS assessments so that their outcome is properly communicated to patients, families (where appropriate) and other professionals so that ongoing support can be provided.

6.28 CPA was used effectively in both Hampshire and Barnsley to promote effective communication between agencies, manage risk and meet Sam's individual needs.

6.29 This case had no previous reports of domestic abuse so MARAC was not a consideration.

7 Whether there were any barriers or disincentives experienced or perceived by Isobel or her family/ friends/ colleagues in reporting any abuse including whether they knew how to report domestic abuse and whether they knew what the outcomes of such reporting might be.

8 Whether family, friends, employers or colleagues were aware – by any means - of any abusive or violent behaviour from the perpetrator prior to the homicide and what they did or did not do as a consequence.

6.30 Isobel's sister described that Isobel experienced what might be coercive controlling behaviour from both Paul and Sam. She was clear that she neither knew nor suspected any physical abuse within the family prior to Isobel's death. However, neither she nor Isobel categorised what was happening as domestic abuse and therefore it seemed not to be a consideration to report it as such.

6.31 Isobel's sister did say, however, that even if Isobel did recognise that she was suffering domestic abuse she would be unlikely to seek external support other than from the police and then only in an emergency. She said it was not in her nature to ask for help

except for medical matters, such as Sam's mental health crises.

6.32 Likewise, Paul did not categorise what he told the review he experienced as domestic abuse, although on his description, it might have been coercive control. He said that even if he had regarded it as abuse, he would be unlikely to seek support from the police or other agency for it.

9 Whether more could be done in the locality to raise awareness or accessibility of services available to victims of domestic violence, their families, friends or perpetrators.

6.33 The unusual nature of this domestic homicide raises many questions about awareness and accessibility of services. Southern Health NHS Foundation Trust have said that their Unit will consider the wider use of promotional material in relation to domestic abuse within its introduction packs as well as posters situated in appropriate places within the hospital, such as toilets. This would reinforce the leaflets they currently have in reception. The leaflet does provide details of local services.

6.34 This review highlights that most domestic abuse services and awareness raising programmes are focused on the most prevalent form of DVA; adult on adult. However, there are services and information resources available that help support those who are, or are at risk of, being abused by their adolescent children.

6.35 Locally, STOP Domestic Abuse's Adolescent to Parent Abuse provision consists of a six session group work, educational/therapeutic programme for parents/carers of a child/ young person who is acting abusively towards them or beyond their control. This is suitable for clients with children displaying challenging and potentially abusive behaviour. The criteria for a client to be referred is that the challenging child is between the ages of eight and sixteen. The main goal is to empower parents, reducing stress and guilt and giving them concrete strategies.

Recommendation 5

The Winchester Community Safety Partnership should develop a communications strategy which has the ambition of ensuring that the nature of domestic abuse, in all its forms (including 'adolescent to parent' abuse and coercive control) is recognised and the reach and accessibility of both statutory and specialist support services is such that people in every community are clear on where to seek help for themselves and others in a way which meets their needs.

10 Whether Isobel's, Paul's or Jane's previous experience of services may have had an impact on their likelihood of seeking support during the period under review.

6.36 Isobel and Paul's family had very little draw on services before these events. When they did they were able to engage fully and constructively with them. They seemed able to raise issues, challenge responses, state their concerns and focus on outcomes.

6.37 Paul says his experience as a non-residential parent was that CAMHS did not involve him in Sam's care but that the experience in Barnsley was much better. Isobel and Paul had undergone an acrimonious divorce yet seemed able to work with professionals for the good of their children when they were involved

6.38 Isobel's sister said Isobel would be disinclined to seek support except in urgent situations. She said this may have been cultural – possibly with a misplaced sense of shame – or it may have been a fear over what consequences may follow and her choice in those.

6.39 There is nothing to suggest this reluctance was driven by previous experiences but

may have been aggravated by the nature of the adolescent to parent violence, should it previously have existed, that may have acted as a further barrier.

11 The review will consider any equality and diversity issues that appear pertinent to the victim, perpetrator and dependent children e.g. age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex and sexual orientation.

6.40 Section 4 of the Equality Act 2010, defines protected characteristics as:

- age;
- disability;
- gender reassignment;
- marriage and civil partnership;
- pregnancy and maternity;
- race;
- religion or belief;
- sex;
- sexual orientation.

6.41 Since the enactment of the Equality Act 2010, there has been widespread ambiguity as to whether a person who is non-binary (or agender) as Sam was, has a protected characteristic under either 'gender reassignment' or 'sex'. A recent employment tribunal *Ms_R_Taylor_V_Jaguar_Land_Rover_Ltd (2018)* (decided in September 2020,) clarifies that discrimination on the basis of the claimant being non-binary is unlawful under the Equality Act.

6.42 No agency subject to this review argued that they did not have a duty to meet Sam's non-binary needs so this review has progressed with an acceptance that they did.

6.43 Sam will have been struggling with their gender identity for some time but on their sixteenth birthday, they changed their name and told people of their decision and its implications. Their school adapted swiftly and staff were told, not only of their decision, but what it meant in terms of adjustment to the otherwise gender-specific policies and practices. Occasionally, in written communications, staff would slip in to using male pronouns and that was the same for a number of agencies.

6.44 The Southern Health Tier 4 Mental Health Inpatient Unit, on the other hand struggled to adapt. Of course, they admitted Sam at very short notice and would have faced a fait accompli in terms of adjusting. Gender specific bedroom areas, lounges and bathroom facilities troubled Sam. The Unit did rename the lounges but it is unclear whether the perception changed. It seems they could not or did not make other adjustments to suit agender patients. There is no sense that the facility was averse to accommodating Sam's needs but Paul raised the question how well equipped are any settings in meeting non-binary requirements and how committed they were beyond the basics.

Recommendation 6

Winchester Community Safety Partnership should support provider services, across all sectors, in accessing guidance to help them adjust services to meet the needs of agender and non-binary clients assuring the implementation of those adjustments is relevant to their sector. This should include raising awareness of staff and providing appropriate training as needed.

6.45 Whilst this did not manifest itself overtly during the review, the panel did question whether there may have been some ambiguity due to Sam's age at the time under review – fifteen to seventeen years. The Home Office Information Guide, *'adolescent to parent violence and abuse (APVA)*[5]' sets out *'The cross-Government definition of domestic violence and abuse is 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 psychological, physical, sexual, financial and emotional abuse. While this definition applies to those aged 16 or above, APVA can equally involve children under 16, and the advice in this document reflects this.'*

6.46 Therefore, up to and beyond sixteen, Sam was capable of APVA. Over sixteen this would fall under the definition of Domestic Violence and Abuse. However, until they were eighteen, insofar as clinical services and the law are concerned they remained a child. Unpicking this apparent anomaly does not fall within the scope of the review but does pose the question, how well equipped are health services and the police to meet the challenges of children and young people who are or may present a risk of domestic violence? Is there appropriate focus as there would be with over 18s in otherwise identical circumstances?

7 CONCLUSIONS

7.1 This review has highlighted that, whilst not previously known to services, some adolescents can present a significant risk to their family members if, on the rare occasions they do present, assessment, information sharing and effective family engagement are not at optimum levels.

7.2 Whilst Isobel did raise her concern about Sam's mental state, the risk she felt they presented (albeit to themselves) and her real concerns should they be discharged without support, she was not always heard, nor was Paul. Despite them being irrevocably estranged, both genuinely loved and wanted the best for their children but they weren't always spoken to or heard.

7.3 There were clinical and risk assessments which were either undocumented or carried out with incomplete information. Had this not been the case more would have been known by the agencies that assumed Sam's care and perhaps provision may have been more bespoke to their condition, needs and wishes.

7.4 The tragedies this family have endured are unimaginable but it would be a fitting legacy to them, especially Isobel, if the lessons from this review are embedded in services as soon as possible to reduce the risk of similar events in the future.

[5] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/732573/APVA.pdf

RECOMMENDATIONS

Recommendation 1.

Sussex Partnership NHS Foundation Trust should review CAMHS engagement with non-residential parents when assessing or providing treatment to patients so as to glean a fuller understanding of their life and needs.

Recommendation 2.

The Hampshire Clinical Commissioning Groups, Safeguarding Children Partnership, Safeguarding Adults Boards and health providers (whether NHS or private) should, as a matter of urgency, agree a consistent policy and practice to support routine and targeted enquiry for all forms of domestic abuse which ensures that every opportunity is taken to identify where such abuse may be being perpetrated and to signpost or offer services appropriate to need.

Recommendation 3.

Where possible, health providers health providers involved in this review should assure themselves that in assessing risk to others, their tools and practices embrace all assessments, presentations, ideations and views of third parties to triangulate any expressed or reported risk so as to effectively establish the risk level and the management plan aimed to reduce it.

Recommendation 4.

Priory Hospitals review how it assesses, diagnoses and communicated ADOS assessments so that their outcome is properly communicated to patients, families (where appropriate) and other professionals so that ongoing support can be provided.

Recommendation 5.

The Winchester Community Safety Partnership should develop a communications strategy which has the ambition of ensuring that the nature of domestic abuse, in all its forms (including 'adolescent to parent' abuse and coercive control) is recognised and the reach and accessibility of both statutory and specialist support services is such that people in every community are clear on where to seek help for themselves and others in a way which meets their needs.

Recommendation 6.

Winchester Community Safety Partnership should support provider services, across all sectors, in accessing guidance to help them adjust services to meet the needs of agender and non-binary clients assuring the implementation of those adjustments is relevant to their sector. This should include raising awareness of staff and providing appropriate training as needed.