PENDLE COMMUNITY SAFETY PARTNERSHIP

DOMESTIC HOMICIDE REVIEW

'Charles'

Died: May 2020

OVERVIEW REPORT

December 2023

Chair and Author: Carol Ellwood-Clarke QPM
Independent support to Chair: Ged McManus

CONTENTS

Family Tribute to Charles

'The second son of 7 children, he was a quiet man with a huge caring heart.

Charles was a huge Burnley Football Club supporter, who also loved darts, Status Quo and dogs. They were his passions in life.

Charles worked hard all his life and was taken from us just as he was planning his retirement.

He did not deserve to die in the way he did.

The devastation of his death has been unbearable for all the family both emotionally and mentally. We will never get over his death, but he lives on in our hearts and thoughts every day and that will never change'.

1. INTRODUCTION

1.1 The panel offers its sincere condolences to Charles's family.

1.2 This report of a Domestic Homicide Review examines how agencies responded to, and supported, Charles, a resident of Pendle, prior to his murder in the summer of 2020.

1.3 'In addition to agency involvement the review will also examine 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 the future safer'.

1.4 'The key purpose for undertaking Domestic Homicide Reviews is to enable lessons to be learned from homicides where a person is killed as a result of domestic violence and abuse. In order for these lessons to be learned as widely and thoroughly as possible, Professionals need to be able to understand fully what happened in each homicide, and most importantly, what needs to change in order to reduce the risk of such tragedies happening in the future[1]'.

1.5 Charles was the father of Bill: who was his only child. They lived together in Pendle, in the family home.

1.6 Charles was found deceased at his home address. Charles had a deep laceration to his neck. He was holding a knife in his right hand. Bill was found in the rear yard of the house. Bill had lacerations to his arms, neck and a deep laceration to his leg. A knife blade was discovered hidden under Bill's right arm. A Home Office post-mortem determined that on the balance of probability, Charles died from hypovolaemic shock (profound haemorrhage causing circulatory collapse to the extent that blood supply to the vital organs was fatally compromised) caused by multiple stab wounds to his neck. It could not be excluded that the blunt force head injuries contributed to, or even caused, Charles's death. The overall findings being that Charles died as a consequence of a sustained and forceful multi-mode assault.

1.7 Bill was arrested on suspicion of the murder of Charles and subsequently charged with his murder. Bill had had recent contact with mental health providers prior to the murder of Charles.

[1] https://www.gov.uk/government/publications/revised-statutory-guidance-for-the-conduct-of-domestic-homicide-reviews

1.8 In October 2021, Bill pleaded guilty to the manslaughter[2] of Charles on the grounds of diminished responsibility. In December 2021, Bill was sentenced to an indefinite hospital order[3] combined with a life sentence. The Judge ruled that if Bill was ever ruled well enough for release from the hospital setting, then he would then have to start a life prison sentence because of the danger he poses to the public. Bill would then have to serve a minimum of 12 years of that life sentence before he would be eligible to go before the Parole Board.

1.9 The report was seen by Charles's family who have contributed to the review and DHR process. The DHR panel thank the family for their contribution.

[2] https://www.sentencingcouncil.org.uk/offences/crown-court/item/manslaughter-by-reason-of-diminished-responsibility/
A conviction for manslaughter by reason of diminished responsibility necessarily means that the offender's ability to understand the nature of the conduct, form a rational judgment and/or exercise self-control was substantially impaired.

[3] Section 37/41 hospital order with restrictions, this is an "indefinite" order which means that there is no time limit to renew the Section as it continues indefinitely until the person is discharged by the Secretary of State for Justice or the Mental Health Tribunal.

2. TIMESCALES

2.1 On 10 June 2020, Pendle Community Safety Partnership determined the death of Charles met the criteria for a Domestic Homicide Review (DHR).

2.2 The first meeting of the Review Panel took place on 29 October 2020. Thereafter, the panel met six times. During the Covid-19 pandemic, panel meetings were held virtually, and contact was maintained with the panel via email and telephone calls.

2.3 The review covers the period of 1 January 2019 to 22 May 2020. The Review Panel agreed on these dates to capture agency contact within the preceding 18 months prior to the murder of Charles. There had been no significant agency contact with the subjects of the review prior to the commencement date.

2.4 The review was presented to Pendle Community Safety Partnership 18 July 2022 and concluded on 14 November 2022 when it was sent to the Home Office.

3. CONFIDENTIALITY

3.1 Until the report is published, it is marked: Official Sensitive Government Security Classifications May 2018.

3.2 The names of any key professionals involved in the review are disguised using an agreed pseudonym. The report uses pseudonyms for the victim and perpetrator. The pseudonyms were agreed with Charles's family.

3.3 This table shows the age and ethnicity of the subjects at the time of Charles's murder.

Name	Relationship	Age	Ethnicity
Charles	Victim	65	White British male
Bill	Perpetrator	32	White British male

4. TERMS OF REFERENCE

4.1 Following the first meeting, the panel settled on the following terms of reference on 29 October 2020. These were shared with the family who were invited to comment on them.

4.2 **The purpose of a DHR is to:**

- establish what lessons are to be learned from the domestic homicide regarding the way in which local Professionals and organisations work individually and together to safeguard victims;
- identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result;
- apply these lessons to service responses including changes to inform national and local policies and procedures as appropriate;
- prevent domestic violence and homicide and improve service responses for all domestic violence and abuse victims and their children by developing a co-ordinated multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest opportunity;
- contribute to a better understanding of the nature of domestic violence and abuse; and
- highlight good practice.

Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews [2016][4] Section 2 Paragraph 7

4.3 **Specific Terms**

1. What indicators of domestic abuse, including coercive and controlling behaviour, did your agency have that could have identified Charles as a victim of domestic abuse, and what was the response?

2. What knowledge did your agency have that indicated Bill might be a perpetrator of domestic abuse against Charles, and what was the response?

3. What was your agency's knowledge of any barriers faced by Charles that might have prevented him reporting domestic abuse, and what did it do to overcome them?

[4] https://www.gov.uk/government/publications/revised-statutory-guidance-for-the-conduct-of-domestic-homicide-reviews

4. Did Charles have any known vulnerabilities, and was he in receipt of any services or support for these?

5. What risk assessments did your agency undertake for Charles or Bill; what was the outcome, and if you provided services, were they fit for purpose?

6. What were the key points or opportunities for assessment and decision-making in this case? Do assessments and decisions appear to have been reached in an informed and professional way?

7. Did actions or risk management plans fit with the assessment and decisions made?

8. When, and in what way, were the subjects' wishes and feelings ascertained and considered? Were the subjects informed of options/choices to make informed decisions? Were they signposted to other agencies, and how accessible were these services to the subjects?

9. Did the agency have policies and procedures for Domestic Abuse and Safeguarding, and were these followed in this case? Has the review identified any gaps in these policies and procedures?

10. Were there any issues in relation to capacity or resources in your agency that affected its ability to provide services to Charles and Bill, or on your agency's ability to work effectively with other agencies? N.B. Please also consider any additional capacity/resource issues with agency contact during the Covid-19 pandemic.

11. How did your agency take account of any racial, cultural, linguistic, faith or other diversity issues, when completing assessments and providing services to Charles and Bill?

12. What learning has emerged for your agency?

13. Are there any examples of outstanding or innovative practice arising from this case?

14. Does the learning in this review appear in other Domestic Homicide Reviews commissioned by Pendle Community Safety Partnership?

5. METHOD

5.1 Lancashire Constabulary informed Pendle Community Safety Partnership, on 28 May 2020, of the death of Charles. At a meeting held on 10 June 2020, a decision was made that the case met the criteria for a Domestic Homicide Review: The Home Office were notified. On 20 August 2020, Carol Ellwood-Clarke was appointed as the Independent Chair and Author for the review.

5.2 The first meeting of the Review Panel determined the period the review would cover. The Review Panel determined which agencies were required to submit written information and in what format. Those agencies with substantial contact were asked to produce Individual Management Reviews (IMRs).

5.3 The criminal investigation was still ongoing at the time of the commencement of the review. The Senior Investigating Officer (SIO) was consulted by the Chair, and it was agreed that the review could continue in parallel to the criminal case. The SIO consented for the Chair to speak with family to gather background information. The criminal trial was scheduled to take place during April 2021; however, in March 2021, the trial was delayed until October 2021. The review was suspended in May 2021, as further contact with family and Bill could not be undertaken until the conclusion of the criminal trial.

5.4 Charles was still in employment at the time of his murder; however, the Review Panel took cognisance of Charles's age and were supported on the Review Panel by a representative from Age UK Lancashire – to provide advice and guidance.

5.5 In February 2021, the Chair contacted the Head of Patient Safety/Independent Investigations for NHS England and NHS Improvement – North West Region, to seek clarification on the decision to undertake a Mental Health Homicide Review. The Chair was informed that a Mental Health Homicide Review was not being undertaken. The case had been presented to the North Regional Independent Investigations Review Group on 5 October 2020, and the decision based upon the information available at the time was that this case did not meet the criteria for an Independent Mental Health Homicide Investigation. The Chair shared further

information with NHS England and NHS Improvement North West Region who agreed to appoint an independent mental health expert to the panel to provide expert advice and support to the DHR process. The following is included within the terms of reference of engagement:

- To attend panel meetings and provide mental health and investigative expertise to assist the DHR Review Panel and Independent DHR Chair.
- Provide constructive independent challenge to the detail of mental health information provided to the DHR.
- Assist the Independent Panel Chair to determine a health-related chronology.
- To contribute (if required) to the drafting of the mental health element of the DHR Report.

5.6 On 19 July 2021, the Chair presented an interim overview report to Pendle Community Safety Partnership. The report contained the learning and recommendations that had been identified during the DHR until the suspension in May 2021. The recommendations were agreed by Pendle Community Safety Partnership. This process was undertaken to prevent any delay to the implementation of the identified learning and recommendations.

5.7 In addition to the DHR recommendations, individual agencies' learning, and recommendations were reviewed as a separate agenda item at each panel meeting following the submission of their IMRs.

5.8 The DHR recommenced in October 2021, with further panel meetings being held online. Further family engagement commenced after the conclusion of the criminal trial.

5.9 The Chair had access to the psychiatric reports produced by Dr Stephen Barlow, Clinical Forensic Psychiatrist, prepared for the criminal trial. Extracts and references from the report are contained within the report – with the express permission of Dr Barlow.

5.10 Following the conclusion of the criminal trial, the Chair contacted the Clinical Lead responsible for Bill to discuss the DHR process and establish if Bill was medically fit to be seen as part of the DHR. Also, to ascertain if Bill wanted to contribute to the DHR. Bill agreed to be seen and the Chair arranged a visit to see Bill in the company of a member of the nursing team. Bill's contribution is captured in the report, where relevant.

5.11 The Chair of the Community Safety Partnership agreed for an extension of the timeframe for the review due to the delay in the review concluding, and the impact of the Covid-19 pandemic. The Home Office was notified of the extension.

5.12 A copy of the draft report was shared with family, who were invited to make comment.

6. INVOLVEMENT OF FAMILY, FRIENDS, WORK COLLEAGUES, NEIGHBOURS AND THE WIDER COMMUNITY

6.1 The Chair wrote to Charles's brother to inform him of the review, and included the Home Office Domestic Homicide Review leaflet for families and the Advocacy After Fatal Domestic Abuse leaflet (AAFDA)[5]. The letter was delivered by the Police Family Liaison Officer.

6.2 A letter was sent to Charles's ex-wife (mother of Bill) at the commencement of the review. The letter was delivered by the Police Family Liaison Officer. It was known that this lady was suffering with ill health. Following the conclusion of the criminal trial, the Chair spoke to Charles's ex-wife. Relevant information provided during this contact has been included within the report.

6.3 The Chair maintained contact with the Victim Support Homicide Worker for the case – to provide updates for the family at key points in the review process during the criminal investigation and suspension of the review.

6.4 The Chair met with Charles's family, who were supported by their Victim Support Homicide Worker. Charles was one of seven siblings, all of whom survive him. The Chair met with five of the siblings; the eldest sibling was unable to attend the meeting due to poor health and was represented at the meeting by one of their adult children. Charles was described as a very private man, who kept himself to himself. Charles had a friend in Australia who he visited every couple of years. Further information from the family has been included in the report where relevant.

6.5 The Chair contacted the Head of Human Resources of Charles employer. They were unable to provide any information other than basic employment details, which were already known to the review.

6.6 The Chair contacted the employer of Bill. Bill had been on furlough at the time of the incident. There was no relevant information held by Bill's employers.

[5] https://aafda.org.uk/

7. CONTRIBUTORS TO THE REVIEW

7.1 This table show the agencies who provided information to the review.

Agency	IMR[6]	Chronology	Report
Blackburn with Darwen and East Lancashire Clinical Commissioning Group	✓	✓	
Lancashire Constabulary	✓	✓	
Lancashire County Council – Mental Health	✓	✓	
Lancashire and South Cumbria NHS Foundation Trust	✓	✓	
North West Ambulance Service			✓

7.2 The following agencies were written to as part of the scoping process for the review, but held no information:

1. National Probation Service
2. Lancashire County Council Adult Social Care (For victim)
3. Lancashire Fire and Rescue Service
4. Community Rehabilitation Company

7.3 The individual management reviews contained a declaration of independence by their authors, and the style and content of the material indicated an open and self-analytical approach, together with a willingness to learn. All the authors explained that they had no management of the case or direct managerial responsibility for the staff involved with this case.

[6] Individual Management Review: a templated document setting out the agency's involvement with the subjects of the review.

8. THE REVIEW PANEL MEMBERS

8.1 This table shows the Review Panel members.

Review Panel Members		
Name	**Job Title**	**Organisation**
Amanda Baille	Service Manager – Mental Health	Lancashire County Council
Claire Bennett	Chief Executive Officer	Be Free (Formerly Pendle Domestic Violence)
Amelia Brummitt	Specialist Safeguarding Practitioner	Blackburn with Darwen and East Lancashire Clinical Commissioning Group
Carol Ellwood-Clarke	Chair and Author	Independent
Garry Fishwick	Review Officer	Lancashire Constabulary
Wayne Forrest	Localities and Policy Manager	Pendle Borough Council
Emma Foster	District Manager	Inspire[7]
Mathew Hamer	Training Development Manager	Lancashire Fire and Rescue Service
Tim Horsley	Community Protection Co-ordinator	Pendle Borough Council
Dr Karen Massey	Named GP for Safeguarding	East Lancashire Clinical Commissioning Group
Ged McManus	Support to Chair and Author	Independent
Anne Oliver	Community Engagement Manager	Age UK Lancashire
Mark Potter	Mental Health Specialist	NHS England
Lesley Riding	Named Nurse Safeguarding Adults	Lancashire and South Cumbria NHS Foundation Trust

[7] https://www.changegrowlive.org/inspire-east-lancashire/burnley?gclid=CjwKCAjwiuuRBhBvEiwAFXKaNMtsrhDvG2pxYRKev9VKYxFPhoNBNz4CE6pXwqCnYZiqflwiQIg1lBoC9IwQAvD_BwE
We offer a wide range of support for anyone worried about their own or somebody else's substance and alcohol use. We offer advice and guidance to individuals and family members from assessment through to treatment and aftercare. The treatment options we offer include one-to-one key working, group work, detox and rehab, housing support and psychological therapies.

Lee Wilson	Detective Chief Inspector	Lancashire Constabulary

8.2 The Chair of Pendle Community Safety Partnership was satisfied that the panel Chair was independent. In turn, the panel Chair believed there was sufficient independence and expertise on the panel to safely and impartially examine the events and prepare an unbiased report.

8.3 The panel met six times and matters were freely and robustly considered. Outside of the meetings, the Chair's queries were answered promptly and in full.

9. CHAIR AND AUTHOR OF THE OVERVIEW REPORT

9.1 Sections 36 to 39 of the Home Office Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews December 2016, sets out the requirements for review Chairs and Authors.

9.2 Carol Ellwood-Clarke was appointed as the DHR Independent Chair. She is an independent practitioner who has chaired and written previous DHRs and other safeguarding reviews. Carol retired from public service (British policing – not Lancashire) in 2017, after thirty years, during which she gained experience of writing independent management reviews, as well as being a panel member for Domestic Homicide Reviews, Child Serious Case Reviews, and Safeguarding Adults Reviews. In January 2017, she was awarded the Queens Police Medal (QPM) for her policing services to Safeguarding and Family Liaison. In addition, she is an Associate Trainer for SafeLives[8].

9.3 Ged McManus is an independent practitioner who has chaired and written previous DHRs and Safeguarding Adults Reviews. He has experience as an Independent Chair of a Safeguarding Adult Board. He served for over thirty years in different police services in England (not Lancashire). Prior to leaving the police service in 2016, he was a Superintendent with particular responsibility for partnerships including Community Safety Partnership and Safeguarding Boards.

9.4 Between them, they have undertaken the following types of reviews: Child Serious Case Reviews; Safeguarding Adults Reviews; multi-agency public protection arrangements (MAPPA) serious case reviews; Domestic Homicide Reviews; and, have completed the Home Office online training for undertaking DHRs.

9.5 Neither practitioner has worked for any agency providing information to the review.

[8] https://safelives.org.uk/

10. PARALLEL REVIEWS

10.1 The Chair notified Her Majesty's Coroner that a DHR was being undertaken. Her Majesty's Coroner for Lancashire and Blackburn with Darwen opened and adjourned an inquest into Charles's death.

10.2 Lancashire Constabulary undertook a criminal investigation into the circumstances surrounding the death of Charles. Bill was charged with the murder of Charles. Bill pleaded guilty to the manslaughter of Charles and was sentenced in December 2021. [See 1.8].

10.3 Lancashire and South Cumbria NHS Foundation Trust reported the incident on the Strategic Executive Information System (StEIS)[9]. LSCFT completed an internal investigation which produced a comprehensive report with identified learning. The Review Panel requested access to a copy of the investigation report to inform the review. This request was initially declined due to the review being underway; however, following a further request, a copy of the report was shared towards the end of the DHR process. The delay was attributed to consent being gained to allow release of the document.

10.4 The Chair is not aware that any other agency has conducted a review or investigation into Charles's death, nor intends to do so.

[9] https://improvement.nhs.uk/resources/steis/
This system facilitates the reporting of Serious Incidents and the monitoring of investigations between NHS providers and commissioners.

11. EQUALITY AND DIVERSITY

11.1 Section 4 of the Equality Act 2010 defines protective characteristics as:

- **age** [for example an age group would include "over fifties" or twenty-one year olds. A person aged twenty-one does not share the same characteristic of age with "people in their forties". However, a person aged twenty-one and people in their forties can share the characteristic of being in the "under fifty" age range].
- **disability** [for example a man works in a warehouse, loading and unloading heavy stock. He develops a long-term heart condition and no longer has the ability to lift or move heavy items of stock at work. Lifting and moving such heavy items is not a normal day-to-day activity. However, he is also unable to lift, carry or move moderately heavy everyday objects such as chairs, at work or around the home. This is an adverse effect on a normal day-to-day activity. He is likely to be considered a disabled person for the purposes of the Act].
- **gender reassignment** [for example a person who was born physically female decides to spend the rest of her life as a man. He starts and continues to live as a man. He decides not to seek medical advice as he successfully 'passes' as a man without the need for any medical intervention. He would have the protected characteristic of gender reassignment for the purposes of the Act].
- **marriage and civil partnership** [for example a person who is engaged to be married is not married and therefore does not have this protected characteristic. A divorcee or a person whose civil partnership has been dissolved is not married or in a civil partnership and therefore does not have this protected characteristic].
- **pregnancy and maternity**
- **race** [for example colour includes being black or white. Nationality includes being a British, Australian or Swiss citizen. Ethnic or national origins include being from a Roma background or of Chinese heritage. A racial group could be "black Britons" which would encompass those people who are both black and who are British citizens].

- **religion or belief** [for example the Baha'i faith, Buddhism, Christianity, Hinduism, Islam, Jainism, Judaism, Rastafarianism, Sikhism and Zoroastrianism are all religions for the purposes of this provision. Beliefs such as humanism and atheism would be beliefs for the purposes of this provision but adherence to a particular football team would not be].
- **sex**
- **sexual orientation** [for example a man who experiences sexual attraction towards both men and women is "bisexual" in terms of sexual orientation even if he has only had relationships with women. A man and a woman who are both attracted only to people of the opposite sex from them share a sexual orientation. A man who is attracted only to other men is a gay man. A woman who is attracted only to other women is a lesbian. So, a gay man and a lesbian share a sexual orientation].

11.2 Section 6 of the Act defines 'disability' as:

[1] A person [P] has a disability if —

[a] P has a physical or mental impairment, and

[b] The impairment has a substantial and long-term adverse effect on P's ability to carry out normal day-to-day activities[10]

11.3 The Equality Act 2010 (Disability) Regulations 2010 (SI 2010/2128) states that addiction to alcohol, nicotine or any other substance (except where the addiction originally resulted from the administration of medically prescribed drugs) is to be treated as not amounting to an impairment for the purposes of the Equality Act 2010. Alcohol addiction is not, therefore, covered by the Act.

11.4 It should be noted that although addiction to alcohol, nicotine and drugs is excluded from The Equality Act 2010, addiction to alcohol and drugs should be taken into account when a Care Act 2014 (care and support) assessment is completed.

11.5 Charles had been registered at his GP surgery since 2002. There was an entry from 1980 where he had had an episode of hallucinations which had lasted for four days: no cause was found. Due to the time lapse, there was no further information held.

11.6 Charles was not on any regular medication. Reviews were sought from the GP for routine health complaints: the majority of these were managed

[10] Addiction/Dependency to alcohol or illegal drugs are excluded from the definition of disability.

within general practice. Referrals had been made to dermatology and ophthalmology, historically, and these had resolved prior to the commencement of the timeframe of the chronology.

11.7 Bill had a history of mental health issues from as early as 2003, when he was 15 years old. Bill was prescribed antidepressant medication, citalopram[11], and referred to specialist mental health teams. Bill did not routinely comply with his medication. In 2016, Bill was advised to self-refer to Improving Access to Psychological Therapies. There is no record that Bill self-referred. Bill admitted to professionals that he used illicit drugs, such as cannabis and cocaine. During some contacts, Bill described suicidal thoughts.

11.8 In April 2020, Bill was admitted to hospital under Section 2 Mental Health Act 1983. Bill remained in hospital for 10 days, when he was discharged back to the care of his GP. This is addressed under Section 14.

11.9 The Strategic Assessment for Pendle Borough in 2018[12], identified that domestic abuse accounted for 16% of repeat victimisation. The first choice of substance misuse in young people referred into partner agencies is cannabis, then alcohol. Over half the individuals in treatment services for substance misuse are aged between 35-49 years.

11.10 There is nothing in agency records that indicated that Bill or Charles lacked capacity[13] in accordance with Mental Capacity Act 2005.

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[11] https://www.nhs.uk/medicines/citalopram/
Citalopram is a type of antidepressant known as a selective serotonin reuptake inhibitor (SSRI).

[12] https://www.lancashire.gov.uk/media/906685/pendle-2018.pdf

[13] The Mental Capacity Act 2005 established the following principles:

Principle 1 [A presumption of capacity] states "you should always start from the assumption that the person has the capacity to make the decision in question".

Principle 2 [Individuals being supported to make their own decisions] "you should also be able to show that you have made every effort to encourage and support the person to make the decision themselves".

Principle 3, [Unwise decisions] "you must also remember that if a person makes a decision which you consider eccentric or unwise this does not necessarily mean that the person lacks capacity to make the decision".

Principles 1 – 3 will support the process before or at the point of determined whether someone lacks capacity.

11.11 All subjects of the review are white British. At the time of the review, they were living in an area which had a population consisting of 57.8% white[14].

11.12 The Review Panel took account of Charles's age and gender, and reflected on the following research:

In the 12-month period to year ending March 2020: the Crime Survey for England and Wales[15] showed that an estimated 2.3 million adults aged 16 to 74 years experienced domestic abuse in the last year (1.6 million women and 757,000 men), a slight but non-significant decrease from the previous year.

11.13 Research undertaken by Safelives[16] identified that victims of domestic abuse aged over 61 are much more likely to experience abuse from an adult family member, or current intimate partner, than those 60 and under. The report[17] also has the support of Age UK.

11.14 The Review Panel took account of research in relation to the gender bias of male victims of domestic abuse. In 2021, Dr. Elizabeth Bates, University of Cumbria, published a paper following a review of 22 Domestic Homicide Reviews[18]. The research identified that society still did not readily

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Principles 4 [Best Interest] "Anything done for or on behalf of a person who lacks mental capacity must be done in their best interest".

Principle 5 [Less Restrictive Option], "Someone making a decision or acting on behalf of a person who lacks capacity must consider whether it is possible to decide or act in a way that would interfere less with the persons rights and freedoms of action, or whether there is a need to decide or act at all. Any interventions should be weighed up in particular circumstances of the case".
[Mental Capacity Act Guidance, Social Care Institute for Excellence]

[14] The United Kingdom Census 2011 showed a total resident population for Nelson civil parish of 29,135. The town forms part of the wider urban area, which had a population of 149,796 in 2001. The racial composition of the town in 2011 was 57.8% White (53.4% White British), 40.4% Asian, 0.1% Black, 1.5% Mixed and 0.2% Other. The largest religious groups are Christian (39.0%) and Muslim (37.6%). 59.9% of adults between the ages of 16 and 74 are classed as economically active and in work. Pendle is one of the 20% most deprived districts in England and approximately 16% (3,200) of children live in low income families.

[15] https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/bulletins/domesticabuseinenglandandwalesoverview/november2020

[16] http://www.safelives.org.uk/

[17] http://www.safelives.org.uk/spotlight-1-older-people-and-domestic-abuse

[18] https://www.cumbria.ac.uk/about/news/articles/articles/homicide-research-reveals-society-blind-to-male-victims-of-domestic-violence-.php

recognise male domestic abuse victims, and that some may have lost their lives as a result. The research looked at homicides featuring male victims of domestic abuse and found that opportunities to help them were missed due to gender bias and outdated stereotypes. The bias dually inhibited male victims from reporting their abuse, and public support services, such as police and health care, from recognising them as victims. Half of the reviews showed support services lacked guidance to help identify and treat male victims, and a considerable number of men whose injuries were dismissed by the police and other services, as well as friends and family.

11.15 Further references to research around parricide is covered in Section 14.

12. DISSEMMINATION

12.1 The following organisations/people will receive a copy of the report after any amendment following the Home Office's quality assurance process.

- The Family
- Pendle Community Safety Partnership
- All agencies that contributed to the review
- Lancashire Police and Crime Commissioner
- Domestic Abuse Commissioner

13. BACKGROUND, OVERVIEW AND CHRONOLOGY

This part of the report combines the Background, Overview and Chronology sections of the Home Office DHR Guidance overview report template. This was done to avoid duplication of information. The narrative is told chronologically and punctuated by subheadings to aid understanding. The information is drawn from documents provided by agencies and input from Charles's family. The events are cross-referenced to the events table contained within Appendix C. Detailed analysis of the contacts appears at section 14.

13.1 Charles

13.1.1 Charles was the second eldest of his seven siblings. Charles's siblings described a happy childhood with their parents. All of the siblings helped to look after each other and whilst there was not much money to go around, the family took good care of each other. Charles was a much-loved brother to all of his siblings and they miss him very much.

13.1.2 Charles was described as a quiet man who kept himself to himself. He enjoyed a drink and playing darts at his local club. He supported Burnley Football Club avidly and loved walking his dog. He also enjoyed travelling, visiting a friend in Australia regularly: on one occasion, he took his son Bill with him.

13.1.3 Charles met his wife when he was in his 30s. His wife already had two children and the couple went on to have Bill together. When Bill was two or three years old, the couple split up and Charles moved out of the family home. Bill stayed with his mother and her new partner until he was 16, when he moved to live with Charles.

13.1.4 After Charles and Bill's mother separated, Charles had another long-term relationship, but sadly this lady died: Charles remained single after this time. Charles was still working at the time of his murder; he was a caretaker for a local business. Charles had worked for the company for many years and was looking forward to retirement. Following his murder, his work employees raised money for a plaque to be displayed at Burnley's football ground, Turf Moor.

13.2 Bill

13.2.1 Bill was Charles's only child. Bill did not find employment until he was around 23 years old. Whilst Charles was a private man who didn't share

many details, his family were aware that he supported Bill significantly. For example, paying for him to go to football, buying his cigarettes, and paying for him to visit Australia. When Bill did find work, it was generally part-time – he worked in a large retail store, a food factory and, latterly, a leisure centre as a cleaner. Bill informed the Chair that prior to the Covid-19 pandemic, he had been working part-time as a cleaner: a role he had undertaken for about one year. Bill stated that when he was not working, he spent his time at home, looking at the internet.

13.2.2 The family observed that the relationship between Charles and Bill was good. They attended family gatherings together and everyone appeared to get on. Charles's family stated that he was very protective about Bill and would not hear a bad word said against him.

13.3 Events pre-Terms of Reference

13.3.1 In 2003, at the age of 15, Bill was seen by his GP. During the appointment, Bill admitted to using cannabis for 6-12 months as a means to calm himself down. There were reported episodes of self-harm: the first, in 2011, when he had tied a belt around his neck; and, a further incident where he held a knife to his throat.

13.3.2 Bill was referred to Psychiatry, who referred him for bereavement counselling. Bill was prescribed antidepressants but his compliance with the medication was limited. Bill was discharged from Healthy Minds as he failed to attend appointments. No information was held by Healthy Minds to inform the review.

13.3.3 In 2016, Bill presented to his GP on three occasions with low mood. Bill reported to be struggling at home, with concerns that Charles was developing dementia. There was no evidence seen by the Review Panel that Charles had been seen by a health professional in relation to the potential onset of dementia. Bill was signposted to self-refer to Improving Access to Psychological Therapies[19]; however, he did not self-refer. Bill reported an improvement with his mood due to the medication, and that he was receiving support from his family.

13.3.4 In 2016, Bill was arrested for an assault. The victim was a passenger on a bus. The crime was dealt with by way of restorative justice[20].

[19] https://eastlancsccg.nhs.uk/patient-information/your-health/mental-health/iapt-services
[20] https://restorativejustice.org.uk/what-restorative-justice

13.3.5 Charles's family told the Chair that approximately 2-3 years prior to his murder, Bill had assaulted his step-father. The police confirmed that Bill's step-father reported an assault around this time; however, the perpetrator was not identified, and the crime was recorded as undetected. Bill's mother confirmed to the Chair that it had been Bill who had physically assaulted her partner; however, her partner did not provide his details to the police.

13.3.6 Bill told the Chair that he had assaulted his step-father, and that this was in response to witnessing his step-father assaulting his mother, by pushing her over.

Events during the timescales of the review

13.4 2019

13.4.1 In January, Charles attended hospital with a facial injury which was recorded as a 'fall injury to head'. Charles left hospital before he received treatment. Charles had been reported missing to the police by a family member. Two days later, Bill telephoned the police and reported that Charles's injuries were due to an assault. The perpetrator/s were not identified, and the crime was recorded as undetected.

13.4.2 The family told the Chair that they were very suspicious of the circumstances of the assault that Charles reported in January. Bill had telephoned one of the siblings to say Charles was missing and then said that he had been mugged, even before he had been found. After this incident, Charles kept his family at a distance for a while. When one of them saw him a few weeks later, still with extensive bruising on his face, he wouldn't say what had happened and just said: "I don't want any fuss".

13.4.3 Prior to the incident in January, Charles had been in the habit of ringing his brother every Sunday evening when he returned home from having a drink at his club, at 9 pm. After this, he stopped calling for a while and when he did call, the family stated that Charles did not say very much. The family

Restorative justice brings those harmed by crime or conflict and those responsible for the harm into communication, enabling everyone affected by a particular incident to play a part in repairing the harm and finding a positive way forward. This is part of a wider field called restorative practice.

told the Chair that, on reflection, his family wondered now if he was being guarded about what he said because Bill might have been listening.

13.4.4 At the end of January, Charles was seen by a GP and reported that he was struggling with memory and headaches from the assault. Charles was referred for a CT scan and issued with a fit note[21]. After several failed attempts to contact Charles by the GP surgery, he was eventually seen by a GP at the beginning of April, when he received the results of the CT scan.

13.4.5 In June, Bill attended at hospital with a back injury. In August, Bill attended at hospital again with facial injuries sustained during an assault. The matter was not reported to the police, and the perpetrator was not known.

13.5 2020

13.5.1 At the end of January, Bill was seen by a GP with reported concerns of cannabis and cocaine use. Bill stated that he had used cannabis since the age of 12 and had recently started to use cocaine (2-3 bags a day), as well as smoking 20 cigarettes a day. Bill admitted that he had previously had support with his mental health but did not attend follow-up appointments. The GP advised Bill that he needed specialist input from Inspire.

13.5.2 Charles's brother told the Chair that he had been to visit him, prior to his birthday at the beginning of April, and had not been allowed in the house by Bill, which at the time they thought was 'odd'.

13.5.3 On 9 April, Charles and Bill went to a police station. Charles reported that he had been assaulted by Bill, who had slapped him about the head and repeatedly punched him. Charles stated that he had fled the house in the attack and had gone to his ex-wife's home. Charles stated that Bill was suffering with mental health problems. Bill was sat outside the police station but would not engage with officers. Charles stated that Bill was in possession of a rope and had insinuated that he was going to kill himself. Charles declined to make a formal complaint of assault. Bill ran away from the officers towards the railway lines. The officers followed Bill and he was detained under Section 136 Mental Health Act 1983. Bill was taken to a mental health suite at a hospital. Officers submitted a high-risk Vulnerable Adult Police Safeguarding Report for Bill, and a crime report for common assault on Charles. The assault was not investigated further. The

[21] https://www.gov.uk/government/collections/fit-note

Vulnerable Adult Police Safeguarding Report was received in the MASH on 12 May 2020.

13.5.4 On arrival at the suite, Bill tested positive for cocaine and cannabis use on a drug screening test. A Mental Health Act (MHA) assessment was completed with a plan for informal admission into hospital for mental health assessment and support. Bill resisted the informal admission and absconded from the ambulance, which resulted in the police returning Bill to the mental health suite. A further assessment was undertaken, and it was approved under Section 13 Mental Health Act 1983, for an application for detention under Section 2 Mental Health Act 1983. Bill was admitted to hospital.

13.5.5 On 11 April, a clinical entry was made that stated a safeguarding referral may be required due to the violence and aggression towards Charles prior to Bill's admission. A safeguarding referral was not made.

13.5.6 On 14 April, during an assessment, Bill was asked about the assault on his father. Following the assessment, it was decided to arrange a Care Programme Approach (CPA)[22] review – for Bill to self-refer to Inspire and for a review of his Mental Health Act status. Contact was to be made with Charles to ascertain if Bill was able to return to the address.

13.5.7 The following day, the CPA was completed with the following management plan recommended:

- Commence medication, Sertraline 50mg
- Escorted Section 17 grounds leave with staff
- Nursing staff to contact Charles for collateral history and establish whether Bill can stay with Charles once he is discharged from hospital at some point
- Review next week for discharge.

Contact was made with Charles, who agreed for Bill to return to the house.

13.5.8 On 20 April, Bill was discharged. A 48-hour follow-up was arranged with Pennine East Crisis team for the following day. A discharge letter was sent

[22] https://www.nhs.uk/conditions/social-care-and-support-guide/help-from-social-services-and-charities/care-for-people-with-mental-health-problems-care-programme-approach/
The Care Programme Approach (CPA) is a package of care for people with mental health problems.

to the GP surgery (by post). Bill was issued with two weeks' worth of medication. Bill attended the following day with Charles. During the appointment, Bill reported an interest in Talking Therapies[23], and he was provided with the self-referral form for Minds Matter[24]. Bill was also given information on how to access third sector agencies, including contact details of local drug and alcohol services. As the 48-hour follow-up was during the Covid-19 pandemic, phone numbers for the relevant agencies were provided verbally, to enter into the patient's phone or to write down, as leaflets/cards were seen as an infection risk at that time.

13.5.9 On 22 April 2020, following a review of Bill's case, he was discharged from the Home Treatment Team back to the care of the GP. On 30 April, the GP surgery made two attempts to contact Bill to review his medication. These were unsuccessful.

The following information was gathered during the criminal investigation.

13.5.10 On 8 May, Charles encountered a family member in a shop. Charles stated that Bill was "preoccupied with the Covid-19 virus" and had been researching this on the internet. The family member works within a local mental health trust and provided Charles with her phone number in case he wanted to call her for advice.

13.5.11 In the week prior to his murder, Charles visited his former wife several times and reported that their son, Bill, had been acting strangely. Charles was noted to be frightened of returning home. Charles told his former wife that he intended to tell Bill to leave their home at the end of the month. Bill was told by his mother that Charles was going to ask him to leave the property.

13.5.12 The criminal investigation was also informed that Charles had attempted to contact Bill's GP but was unable to do so as the doctor was on holiday.

13.5.13 On the morning of 20 May, Charles called the family member, who he had seen on 8 May, and told her that he had been up all night with Bill. Charles said that Bill "was paranoid" and had been going to the door all night to check it was locked. The family member was concerned that

[23] https://eastlancsccg.nhs.uk/patient-information/your-health/mental-health/iapt-services
[24] https://www.lscft.nhs.uk/Mindsmatter

Charles sounded very tired. The family member made enquiries with colleagues regarding the care of Bill, explaining her personal involvement, and ascertained that Bill had been discharged by the Home Treatment Team back to the care of his GP. The family member enquired about options and contact details, and relayed this back to Charles.

13.5.14 The following day, Charles called the family member again and advised that Bill had stopped taking his medication and had been smoking substances other than tobacco. The family member recalled that Charles sounded much better during this call. Charles was advised to speak with the mental health team. The same day, whilst at work, Charles took a call from Bill and was overhead telling his son to "calm down" and reassuring him that he would sort things out when he returned home. Charles was noted to appear distressed after receiving this call. He told a colleague that his son had mental health problems.

13.5.15 The family told the Chair that they did not know about the assault, which led to Bill's detention under the mental health act, until after Charles murder. The exception to this was the family member who had spoken to Charles in the days before his murder and signposted him to services which might help Bill.

13.5.16 In May 2020, Charles was found deceased. Bill was arrested and charged with the murder of Charles.

14. ANALYSIS USING THE TERMS OF REFERENCE

14.1 Term 1

What indicators of domestic abuse, including coercive and controlling behaviour, did your agency have that could have identified Charles as a victim of domestic abuse, and what was the response?

Blackburn with Darwen and East Lancashire Clinical Commissioning Group

14.1.1 There was no information held within Charles's GP records to identify indicators of domestic abuse. During the timeframe of the chronology, Charles was seen on three occasions at the GP practice – twice by a GP, and once by a practice nurse.

14.1.2 In January 2019, Charles was seen by a GP with recurring ailments following an assault. This was an opportunity for further exploration around the incident, which could have led to a discussion in relation to routine enquiry or Charles's current home circumstances, and an opportunity to disclose domestic abuse.

14.1.3 The panel recognised that routine enquiry is an area that consistently is highlighted through DHRs and has been identified within the Home Office Domestic Homicide Review of 40 cases in 2014/2015 (published 2016)[25]. Of those cases reviewed, there were seven cases of familial homicides, all of which involved a male perpetrator, and six involved with a son killing a parent. Mental health issues were factors in all seven of the familial homicides.

14.1.4 The panel was informed that an EMIS[26] template has been designed between the CCG safeguarding team and EMIS practitioner in response to previous DHR findings for GPs in relation to routine enquiry. The template is designed to pop up when the GP/practitioner enters a problem recorded

25 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/575232/HO-Domestic-Homicide-Review-Analysis-161206.pdf

26 EMIS Health, formerly known as Egton Medical Information Systems, supplies electronic patient record systems and software used in primary care, acute care and community pharmacy in the United Kingdom.

as mental/psychological/emotional health condition. This template is not yet available in all GP surgeries across East Lancashire and Blackburn with Darwen. The template was due to be launched at the start of the Covid-19 pandemic but was trialled at one practice first to ensure it was user-friendly and safe – a further three GP practices have since joined the pilot. These GP practices have been given extra guidance for safe use during telephone consultations, and an audit of use is planned. Full launch of the template is currently on hold due to the Covid-19 pandemic. The panel has seen a copy of the template and guidance issued to GPs around the use of routine enquiry during remote appointments and consultations. The panel recognised this as good practice and has made a recommendation for the CCG to provide an update on the rollout of the template. [Recommendation 1].

Lancashire Constabulary

14.1.5 Lancashire Constabulary had no reported incidents of domestic abuse, prior to the contact with Charles and Bill in April 2020. Lancashire Police had contact with Charles, some 16 months earlier, when a family member reported him as missing. This incident was linked to Charles's attendance at hospital for an assault. The assault was recorded as a crime by the police, but the perpetrator/s were not identified. The family told the Chair that they believed that Bill had been responsible for the assault on Charles.

14.1.6 On 9 April 2020, Charles told the police that he had been assaulted by Bill. Charles had fled the home. Charles attended at a police station with Bill. Charles's primary concern was Bill's mental health, which at that time was in crisis. The police recognised that Charles was a victim of domestic abuse. Due to Bill's presentation, he was detained under Section 136 Mental Health Act 1983.

14.1.7 The police recorded a crime for common assault: it identified Charles as the victim, and Bill as the perpetrator. The police accepted Charles's account that the assault had occurred due to Bill's mental health. The matter was not investigated further, and the case was filed. The police did not complete a DASH risk assessment. A vulnerable adult safeguarding referral was submitted but was not processed in the MASH until 13 May. The referral was risk assessed as high. The referral was for Bill. This is analysed under Term 5.

14.1.8 The crime report was sent, via bulk data transfer, to Victim Support on 13 May. The report did not identify that the assault was domestic abuse but stated: 'Known offender slapped male around the head causing no injury'. Victim Support attempted to contact Charles via landline to offer support,

but contact was not achieved, and the case was closed in accordance with policy.

Lancashire and South Cumbria NHS Foundation Trust

14.1.9 The Trust held information that Charles was a victim of domestic abuse. Information was shared by the police, during a call to the Mental Health Access Line, that Charles had been assaulted by Bill. There was no documented further exploration of this assault with the police.

14.1.10 There were entries in Bill's Electronic Care Records that he had assaulted his father, Charles. Bill was asked about the assault during contact with health professionals. It was recorded that a safeguarding referral may be required; however, this was not actioned, and no referral was submitted. On 19 April 2020, when asked by health professionals if Bill could return to live with him upon discharge, Charles agreed. This information did not prompt any routine enquiry to establish if Charles was at risk of further harm and domestic abuse.

14.1.11 The abuse was not recognised by health professionals as domestic abuse. The review has not been informed why a safeguarding referral was not submitted. LSCFT has identified learning from their involvement in this case and made relevant recommendations.

Lancashire County Council – Mental Health

14.1.12 On 9 April 2020, Lancashire County Council Mental Health received information from the police that Bill had assaulted Charles. This identified that Charles was a victim of domestic abuse.

14.1.13 The panel considered agencies' response to the assault on Charles, and whilst they acknowledged that the initial response was to the mental health of Bill, the panel agreed that the lack of further investigation and support to Charles, in relation to the domestic abuse, was a missed opportunity. Had a DASH been submitted, this would have provided an opportunity for Charles to have been signposted to support services, and for consideration of an assessment regarding his own presenting needs and home circumstances. Charles was not provided with an opportunity to discuss with professionals his relationship with Bill and any indicators of domestic abuse and coercive control. The panel has identified this as learning and made a relevant recommendation. [Recommendation 2].

14.2 Term 2

What knowledge did your agency have that indicated Bill might be a perpetrator of domestic abuse against Charles, and what was the response?

Blackburn with Darwen and East Lancashire Clinical Commissioning Group

14.2.1 The GP surgery held no information that Bill might be a perpetrator of domestic abuse. The letter from the Home Treatment Team (23 April 2020) stated that Charles was supportive of Bill and had attended the follow-up appointment following discharge from inpatient services. No concerns were raised within the letter in relation to their relationship.

14.2.2 There were several risk factors that indicated further exploration was required as to Bill being a perpetrator of domestic abuse. These included the use of illicit drugs and low-level mental health concern, both of which are highlighted as risk factors for perpetration in both elder abuse and intimate relationship domestic abuse (Centres for Disease Control and Prevention 2020)[27]. These factors can put someone at increased risk of being a perpetrator of domestic abuse, which highlights the need for enquiry when consulting on mental health or illicit drug use. The Home Treatment Team had reported in the letter, dated 23 April 2020, that Bill had denied any harm to himself or to others during the appointment.

Lancashire Constabulary

14.2.3 Lancashire Constabulary was not aware until 9 April 2020 that Bill was a perpetrator of domestic abuse. Bill had a previous conviction for a common assault from 2016. The victim in that incident was a member of the public, who Bill verbally abused and then assaulted. The crime was dealt with by means of restorative justice[28] in accordance with the victim's wishes and Lancashire Constabulary's policy at that time.

14.2.4 As detailed in Term 1, the police took no further action against Bill for the assault on Charles. The risk that Bill presented was dealt with in relation to the risk towards himself: around suicidal ideation. Bill was not assessed in relation to the risk he presented to others, and not recognised as a perpetrator of domestic abuse. This is addressed under Term 5.

Lancashire and South Cumbria NHS Foundation Trust

14.2.5 The Trust held information that Bill was a perpetrator of domestic abuse. The police shared this information during the incident on 9 April. On 15

[27] https://www.cdc.gov/violenceprevention/elderabuse/riskprotectivefactors.html
[28] https://www.lancashire.police.uk/about-us/our-commitment/restorative-justice/

April, Bill's mother informed health professionals that Bill had assaulted Charles, which she stated was an isolated incident.

14.2.6 Health professionals discussed the assault on Charles with Bill, whilst he was in hospital. Records stated: 'Bill lives with his father; he was not forthcoming with discussing his father, however when asked about the assault prior to his admission, he became a little fearful and stated that he didn't mean to assault his father, he reported that they had an argument about Covid-19 and things got out of hand. It seems that Bill feels guilt for his actions towards his father; however, he was not willing to disclose any specific details and kept attempting to change the topic of conversation by repeating his reciprocal delusional content'.

14.2.7 There was no documented further exploration of this assault with the police to identify if any criminal investigation was taking place. Whilst it was documented that a safeguarding referral may be required, this was not completed and submitted.

14.2.8 On 21 April 2020, Charles accompanied Bill to the 48-hour follow-up with the Home Treatment Team. There was nothing documented within the record of this visit that Bill was a perpetrator of domestic abuse towards Charles. This was an opportunity to discuss with Charles the domestic abuse, and explore the assault further; however, this did not take place.

14.2.9 The above points do not meet requirements of LSCFT policy Assessment and Management of Clinical Risk in Mental Health Services CL028a: 'Service users and their families/friends/carers should expect that they are competently assessed on a regular and collaborative basis, including an assessment of risk'.

14.3 Term 3

What was your agency's knowledge of any barriers faced by Charles that might have prevented him reporting domestic abuse, and what did it do to overcome them?

14.3.1 The review did not identify any knowledge that agencies had which prevented Charles reporting domestic abuse.

14.3.2 The review considered why Charles did not report domestic abuse prior to the incident on 9 April 2020. The panel considered that there may have been a lack of knowledge by Charles and the wider community that the circumstances of the incident in April constituted domestic abuse.

14.3.3 Charles was present with Bill when health professionals discussed discharge planning in April 2020. The incident of the assault, that had led to Bill's admission, had not been recognised as domestic abuse, and therefore when decisions were being made about Bill returning to the family home, these discussions took place in the presence of Charles. Charles was not provided with the opportunity to speak privately about his view on Bill returning home. Nor did it provide an opportunity for Charles to disclose domestic abuse. The Review Panel was clear that this approach demonstrated gender bias, and a lack of awareness of the wider definition of domestic abuse. The Review Panel agreed that this approach would not have occurred had Charles been a female. The family told the Chair that they agreed that there was gender bias demonstrated towards Charles. The family also told the Chair that the report has documented that Charles was not given an opportunity to be spoken to on a 1-1 basis to allow professionals to understand the circumstances of his home life situation.

14.3.4 The Review Panel also considered other pressures on Charles in allowing Bill to return to the family home and discussed the potential reliance of Bill on Charles in terms of financial support. The Review Panel were aware that financial abuse is an indicator of domestic abuse and an aspect of coercive control, and that financial abuse involves similar behaviours to economic abuse. Surviving Economic Abuse[29] (a UK charity) provides detailed information, which the Review Panel considered against the information gathered on this case, to help inform the panel's discussions. The Review Panel did not identify that Charles was a victim of financial and/or economic abuse from Bill.

14.3.5 At the time of Bill's discharge from hospital the country was subject to restrictions that the Government had put in place due to the Covid-19 pandemic. Whilst the Review Panel recognised that this could have placed some pressure on allowing Bill to return home; the Review Panel saw no direct evidence of this within agencies records.

14.3.6 The panel recognised that parricide (the killing of a parent by a child) is a rare and currently neglected area of research. The Review Panel is aware of some recent research in the UK[30]. While the research provides some interesting findings, it does not provide any insight into the barriers that parents may face in reporting abuse by children.

[29] https://survivingeconomicabuse.org/what-is-economic-abuse/
[30] Dr Hannah Bows Durham Law School: Where parricide meets eldercide: an analysis of child to parent/grandparent homicides in the UK.
https://dro.dur.ac.uk/26829/

14.3.7 The panel noted research by Dr Kathleen M Heide, University of South Florida, which describes typologies of parricide[31] and whilst this research is from America the Review Panel thought it was valuable to include. The research describes three typologies as follows:

The severely abused parricide offender

This is the most common type of adolescent parricide offender, where there is generally long-standing abuse in the home. These offenders feel they are in danger, they are being threatened and they cannot see a way out: they kill in response to terror or desperation. Often, they have tried to get help in the past, maybe by telling another family member who does not live inside the home, but they have not been believed or no intervention has taken place to improve their situation.

They often kill as they can no longer deal with their situation. Psychological abuse can be present alongside physical, sexual or verbal abuse – either directed at them or at someone else within the home which they witness. Generally, in these cases, there is no history of mental illness that has been diagnosed or is known to their family. However, there can be long-standing depression and possibly Post Traumatic Stress Disorder, which is realised after the murder takes place.

The severely mentally ill parricide offender

Adult offenders are often diagnosed as severely mentally ill and in adolescent offenders findings often indicate they were gravely mentally disturbed at the time of the murder. Most often there is a diagnosed long-standing mental illness and the killing of a parent or both parents is directly related to the mental illness in these cases.

Offenders may have hallucinations, either visual or auditory, where they are seeing things and or hearing voices which are not there. These voices can be perceived as being a higher power, such as God, telling them to kill their parents. They are most often on psychotropic medication to control their

[31] Why kids kill parents, child abuse and adolescent homicide

https://www.ojp.gov/ncjrs/virtual-library/abstracts/why-kids-kill-parents-child-abuse-and-adolescent-homicide

condition, and killings can take place when they stop taking this medication. When there are multiple victims or unusual weapons are used within murders, severe pathology at the time of the murder is more likely**.**

The dangerously anti-social parricide offender

This type can be found in both adolescent and adult offenders, and they kill for primarily selfish reasons. The parents might be in their eyes, 'in the way', stopping them doing what they want to do. It could be to get hold of their parents' money or simply have more freedom. These offenders usually have a long history of antisocial and criminal behaviour. They may lack emotion or empathy for others, showing psychopathic traits. These offenders know what they are doing and they are trying to gain something for themselves.

14.3.8 There is an increasing recognition within the UK of Adolescent to Parent Violence and Abuse (APVA). An information guide published by the Home Office states[32]:

'There is currently no legal definition of adolescent to parent violence and abuse. However, it is increasingly recognised as a form of domestic violence and abuse and, depending on the age of the child, it may fall under the government's official definition of domestic violence and abuse'.

14.3.9 The guide provides some important information to practitioners and, in particular, some of the barriers that parents may face. Whilst it was recognised that Bill was not an adolescent when he killed his father, there was still a parent/child relationship. Hence, the panel felt some of the information in the guide may be applicable in this case. This included the use of illicit drugs and low level mental health, as an adult, and as Bill was still living in the same household as Charles, this meant there may still have been more of an adolescent to parent relationship rather than an adult child to parent one. The guide states that all forms of domestic violence and abuse are under-reported and parents are, understandably, particularly reluctant to disclose or report violence from their child.

'Parents report feelings of isolation, guilt and shame surrounding their child's violence towards them, and fear that their parenting skills may be questioned and that they will be blamed or disbelieved by those to whom they disclose the violence[33]'.

[32] Information Guide: Adolescent to Parent Violence and Abuse https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/732573/APVA.pdf
[33] Op. cit. p5

14.3.10 Research by the panel identified only one publication was specifically targeted at parents who experience abuse from adult children[34]. The publication identifies the following that may be barriers to parents reporting abuse:

- Feeling alone – that this doesn't happen to other parents.
- Feeling isolated or distanced from other family members and friends.
- Feeling that you want the abuse to stop, not the relationship with your adult child.
- Feeling as a parent you need to protect your child regardless of their age.
- Feeling that you deserve the abuse as a punishment for things that may have happened in the past.
- Feeling scared to disclose the abuse or that the abuse should be kept a secret.
- Feeling that as a parent, you are responsible for the person your adult child has become, and therefore the abuse.
- Feeling shame and guilt – that you have failed as a parent.
- Feeling pressure to keep your family together or that by seeking legal protection, you are being a bad parent.

14.3.11 The Review Panel also considered research which shows that older victims of abuse are likely to have lived with abuse for prolonged periods of time before seeking help. Physical health and dependency for others to care for them, as well as isolation, can all be factors in the decision made by older victims of abuse to remain silent. The panel has not been able to identify if any of the factors in the preceding paragraphs applied in this case.

14.3.12 Pendle Community Safety Partnership website provides information for victims of domestic abuse[35]. This includes information and links to support for male victims of abuse, and a link to Hourglass – support specifically for harm and abuse to older people. The panel acknowledged the work that is currently ongoing, but agreed that there is a need to raise awareness amongst professionals and the community around the learning from this case, and identification of domestic abuse within familial settings. The panel has made a relevant recommendation. [Recommendation 2].

14.3.13 During the completion of this review, and as a result of the learning identified during panel meetings, Age UK Lancashire reviewed the

[34] Adult Child to Parent Violence and Abuse: Belfast Area Domestic and Sexual Violence and Abuse Partnership https://nipsa.org.uk/attachments/article/268/Adult_to_Parent.pdf
[35] https://www.pendle.gov.uk/info/20031/community_safety/48/domestic_violence

Safeguarding section of their website and commenced work on updating it, with local contact details and information on different types of abuse – also to encourage family members to seek help. A copy of Age UK action plan to address this learning has been included in the report at Appendix D.

14.4 Term 4

Did Charles have any known vulnerabilities, and was he in receipt of any services or support for these?

14.4.1 Charles and Bill were registered at different GP surgeries. The information that Bill told a GP, in 2016, that Charles was in the early stages of dementia was not known by Charles's GP. The knowledge that the GP had that Bill had mental health concerns and was using illicit drugs may have had an impact on Charles. Charles had not accessed a GP during the time of Bill's mental health deterioration and therefore had the information been shared, it would have provided an opportunity for signposting and support to have been discussed. There were no records that Charles had been diagnosed or seen with the early stages of dementia. There were no flags on the GP records to suggest any vulnerability.

14.4.2 The learning highlights how routine enquiry regarding home life and personal circumstances should be undertaken when a patient attends with difficulties around mental health, or following an alleged assault. [Term 1 and 12].

14.4.3 No other agency held information of known vulnerabilities. Charles was not in receipt of services or support.

14.5 Term 5

What risk assessments did your agency undertake for Charles or Bill; what was the outcome, and if you provided services, were they fit for purpose?

14.5.1 The review has already identified the learning around the use of routine enquiry within the GP surgery and therefore will not repeat that here. [See Term 1].

14.5.2 There were no risk assessment completed by Bill's GP surgery. Bill was scheduled to have a mental health review with a GP on 30 April 2020. The review did not take place. The review was part of the discharge plan from hospital. The panel was informed that the GP practice policy for reviews is – a telephone call is made, if no answer, a written reminder including SMS/letter and patient message on the prescription is completed to inform the patient to book an appointment for a review. Where there are repeated failures to engage in a review then consideration is given to reduce the quantity of medication issued each time to try and engage the patient. This decision is made on a case-by-case basis. The following details how the process was implemented for Bill:

23 April – discharged by Mental Health Team

30 April – medication reviewed by Pharmacist

30 April – two attempts by a GP to contact Bill via telephone for medication review.

As Bill was stable and had only been discharged the previous week, and had recently had direct access to the Mental Health Team, a letter was not sent to Bill to remind him to book an appointment.

<u>Lancashire Constabulary</u>

14.5.3 Lancashire Police did not complete a DASH risk assessment. A Vulnerable Adult Police Safeguarding Report was submitted in relation to Bill, and assessed as high risk. The report was received in the MASH on 13 May 2020. The report stated that Adult Social Care checks were not carried out. The reason for this was not recorded. A decision was made not to share with agencies. The rationale was that the incident had been reported to the police on 9 April, and only received in the MASH on 13 May: following the incident, Bill was taken to hospital and Charles was deemed to be safeguarded. It was confirmed by Adult Social Care that a referral was not received by the mental health safeguarding team for any alerts relating to Bill, as either the potential perpetrator for domestic violence or as a general alert regarding his mental health. There was no record of Charles having been referred to Adult Social Care.

14.5.4 The panel considered the delay of five weeks from the incident occurring to the Vulnerable Adult Police Safeguarding Report form being submitted and reviewed within the MASH. The panel was informed that, at that time,

there were considerable backlogs of referrals within the MASH (waiting to be reviewed and assessed), and that it was likely that the form was missed within the queue of referrals. The panel was informed that Lancashire Constabulary has changed the process for the submission of Protecting Vulnerable People (PVP) referrals. Officers now create an investigation on the CONNECT system and place a tick box in a section within that investigation that refers the incident directly into the MASH. The MASH then decides which pathway and with whom the case will be shared. The panel was informed that there are no longer delays within the MASH processes, and referrals are shared within a timely manner.

14.5.5 The learning from this case for Lancashire Constabulary has been identified in a DHR commissioned by Blackpool Community Safety Partnership in 2019: this concluded early 2021. The below recommendations from that review were:

1. Lancashire Constabulary to ensure the correct recording and risk grading of incidents of vulnerability.
2. Lancashire Constabulary to reinforce current DA policy with regard to the correct recording of DA incidents when other significant factors within the household appear to be the main concern, i.e. mental health and substance misuse.

The Review Panel has been provided with evidence by Lancashire Constabulary on actions that have been undertaken to address these recommendations – including the use of Vulnerability Coaches who disseminate learning to front-line officers, and ensuring that the learning from previous reviews has been included within training packages. These events occurred after the timescales for this review. Lancashire Constabulary has informed the DHR panel that they are undertaking an audit in relation to the recommendations. The DHR panel has made a recommendation for Lancashire Constabulary to provide an update to Pendle Community Safety Partnership on the outcome of this audit, and learning from the Blackpool DHR. [Recommendation 3].

<u>Lancashire and South Cumbria NHS Trust</u>

14.5.6 A risk assessment was conducted with Bill: this was updated seven times during his time in hospital. This included 5p formulation[36] – as required within the LSCFT Assessment and Management of Clinical Risk in Mental Health Settings Policy Reference Number CL028A.

[36] The 5Ps highlight an approach that incorporates Presenting, Predisposing, Precipitating, Perpetuating, and Protective factors to a consumer's presentation.

14.5.7 Within the enhanced risk assessments, there was information about risk of harm to self, harm to others, and vulnerability. Whilst there is reference to the alleged assault of Charles, Bill was deemed to be low risk to others. Up to the point of his final assessment prior to discharge, there was documented evidence of possible risk to himself, due to his paranoia and voiced suicidal ideation. Bill was assessed as being vulnerable as a result of impulsiveness and use of illicit substances (cannabis and cocaine). The risk to Charles was specifically not considered or recorded within the risk assessment.

14.5.8 The first two enhanced risk assessments were completed by the '136 Nursing Team' following initial detention and subsequent Mental Health Act assessments. Within these risk assessments there was reference to the reported argument between Bill and Charles. The argument was due to Bill's paranoid beliefs around the Covid-19 pandemic and paedophilia. There was reference to the assault on Charles by Bill; however, it was noted that the information about the assault was limited. As detailed in Term 1 and 2, this was not actioned.

14.5.9 Four further enhanced risk assessments were completed as part of the admission process, and response to changes in presentation, progress and treatment plan changes. Within these risk assessments it was documented that Bill presented as low risk of harm to others. Bill had not presented with any threatening or aggressive behaviour whilst under the care of the ward team. In each of the enhanced risk assessments, it stated that: 'It was reported that Bill assaulted his father (Charles) prior to admission, and this may have been reported to police. There is limited information available regarding the assault on Charles, whom Bill lives with. This may require safeguarding referral'.

14.5.10 The final enhanced risk assessment was completed by the Home Treatment Team clinician who completed the 48-hour follow-up review. There were no risks to self, others, or vulnerabilities evident within the 48-hour follow-up.

14.5.11 Whilst each of the risk assessments provided a narrative update upon Bill's progress, presentation and reduction of risk, each of them included information taken directly from the previous risk assessment. There was no documentation to indicate that the team had sought further information about the assault from Charles, or from the police. Bill was reported to have been apologetic about the incident but had not provided any level of detail about the incident.

14.5.12 The panel was informed that the above points did not meet the standards set within LSCFT Assessment and Management of Clinical Risk in Mental Health Settings policy, which states: 'Service users and their families/friends/carers/ should expect that they are competently assessed on a regular and collaborative basis, including an assessment of risk'. There were missed opportunities to seek further information from Charles, other family members, and agencies about the assault and possible domestic abuse. There also was an opportunity for professionals to have sought advice from LSCFT safeguarding.

14.5.13 Enhanced risk assessments completed throughout the admission, document the risk of vulnerability due to substance misuse. Whilst Bill was apologetic about the assault on Charles, he remained guarded and did not elaborate on the assault, or their relationship. Bill was advised to abstain from using drugs; however, it was not documented that he was advised to refer to substance misuse services. The panel concluded that Bill's deterioration in mental state and behaviour was viewed in the context of substance misuse: without consideration of the impact and risks around domestic abuse.

14.5.14 The mental health expert appointed to the review informed the panel that LSCFT should have raised a safeguarding referral in light of Bill's assault on Charles. There was a lack of scrutiny and professional curiosity in relation to the assault on Charles. There was a lack of detailed inquiry into the circumstances leading up to the assault, which appeared to have been out of character. In particular, whether the assault had been secondary to delusional ideation that Bill may have developed relating to his father (Bill was reported to be describing delusional ideation during the course of his admission). Without clarification regarding the reasons behind the assault, the risk assessments carried out could not accurately determine the level of risk that Bill presented to Charles. There was also no clear diagnosis of Bill's presenting mental health conditions.

14.5.15 The panel observed that there was no prior record held within agencies that documented a history of aggression by Bill towards Charles. The reason for the assault by Bill on Charles in April 2020, was not explored whilst Bill was in hospital. Bill told health professionals that he did not wish to discuss the assault, and this appeared to have been accepted. The panel sought clarification from LSCFT as to whether the risk assessment was robust in addressing the following points:

- in understanding the reason for the assault, was this understood, questioned and risks identified, and

- how was the decision made to establish that it was safe to allow Bill to return to live with his father, and that any risks had been eliminated?

14.5.16 In response to the above queries, LSCFT provided further information to the panel in that:

Bill's initial presentation was suggestive of suspected psychosis. However, during the brief admission, the psychotic symptoms were felt to be due to drug-induced psychosis and Bill was diagnosed with mixed anxiety and depression on discharge. The LSCFT internal investigation found that the assessment of Bill suffered from confirmatory bias and did not seek to find evidence beyond the possible working hypothesis of a mixed anxiety and depression.

An enhanced risk assessment tool was undertaken during the admission and was the key document relied upon. However, there was no further review of what the tool had/had not uncovered or how this fitted into the overall assessment and care planning.

The internal investigation also highlighted gaps in relation to assessment, not exploring further regarding substance misuse, safeguarding concerns, need for a carer's assessment, risk of harm to Charles, risk of harm to self, or the need for handing over for further assessment of all of these to the Home Treatment Team on discharge.

LSCFT informed the panel that they acknowledged the findings of their internal report and an action plan had been agreed for a number of essential improvements recommended in that report.

14.5.17 The report was shared with the Review Panel towards the end of the DHR process. The Review Panel identified that Pendle Community Safety Partnership needed to have assurances that the learning from the internal investigation was being addressed and embedded into practice, and have made a recommendation for LSCFT to provide updates to Pendle Community Safety Partnership. [Recommendation 5].

14.5.18 LSCFT services are aligned with other services, including substance misuse services through the Pan Lancashire Dual Diagnosis joint working agreement. The panel was informed that feedback from the introduction of the East Lancashire Dual Diagnosis panel had seen significant improvements and joint working to improve dual diagnosis for service users, and that further work and development is taking place to include – co-location/shadowing, etc. However, this has been delayed due to Covid-19 restrictions. The panel acknowledged that there was a missed opportunity in April 2020 for interagency joint working which may have

offered the opportunity for further support and assessment. LSCFT has identified this as an area for learning and made a relevant recommendation.

Lancashire County Council – Mental Health

14.5.19 Three separate risk assessments were completed with Bill. Each time he was assessed by an Approved Mental Health Practitioner (AMHP). The risk assessments used have been specifically developed to address all areas of potential concern, including risk of harm to self or others, and any historical information that may be relevant. The assessments provide the assessor with an opportunity to detail how identified risks are to be managed.

14.5.20 Bill's first assessment took place following his detention under Section 136 Mental Health Act. This was Bill's first contact with Lancashire County Council Social Care Services. After an initial agreement for informal admission, it was established that Bill was experiencing more significant difficulties with his mental wellbeing than first exhibited and required a further assessment. This led to a second assessment and an application for detention under Section 2 Mental Health Act. The panel was informed that it was unclear at this point whether Bill's problems were related to drug use or to increased stress he was experiencing as a result of the Covid-19 restrictions. At the point of Bill being admitted to hospital, no further referrals were made to Social Care for follow up within the community or discharge from hospital. The IMR author from Lancashire County Council has identified this as an area of learning and made a relevant recommendation.

14.5.21 Bill's third assessment was following his arrest for the murder of Charles. The details of this assessment are outside the timescales for this review.

14.6 Term 6

What were the key points or opportunities for assessment and decision-making in this case? Do assessments and decisions appear to have been reached in an informed and professional way?

14.6.1 The first opportunity for assessment and decision-making on this case was on 9 April 2020. The police have two powers assigned to them under the

Mental Health Act 1983[37] – Section 136 and Section 135. Under Section 136, the police have a power to detain a person who they think has a mental illness and is in need of 'care and control'. The police can use this power to take a person to a place of safety, such as a hospital. The decision to detain Bill under Section 136 Mental Health Act was appropriate given the presenting risk that he posed to himself at that time.

14.6.2 The police should have completed a DASH risk assessment with Charles. The assault was domestic abuse, and although Charles stated that he did not wish to make a complaint of assault to the police, this did not prevent a DASH taking place. As detailed in Term 1, this would have provided an opportunity for Charles to have been signposted to agencies for advice and support.

14.6.3 On 15 April 2020, Bill had a CPA review, following which it was agreed that he would commence on medication and reviewed for discharge the following week. The panel was informed that this was an appropriate timescale.

14.6.4 All Mental Health Act assessments are required by law to be undertaken by an AMHP – trained and approved under Section 13 of the Mental Health Act 1983. In addition, two medical practitioners are required to undertake the assessment and provide their medical opinion and recommendations as to an individual's needs for further assessment and treatment. At least one, and preferably both, of these medical practitioners is required to be trained and approved under Section 12 Mental Health Act to ensure that they fully understand the processes required under a Mental Health Act assessment.

14.6.5 All conclusions to the assessments undertaken on Bill were met through informed and thorough discussion between all professionals involved, i.e. the AMHP and attending medical practitioners, all of whom were Section 12 approved.

14.6.6 Term 5 provides further details of the assessments that were undertaken by mental health professionals, and the outcomes of these contacts whilst Bill was in hospital and upon discharge.

14.6.7 Term 5 provides details of the scheduled medical review on 30 April at Bill's GP surgery.

14.7 Term 7

[37] http://www.legislation.gov.uk/ukpga/1983/20/section/136

Did actions or risk management plans fit with the assessment and decisions made?

14.7.1 It was clearly documented that there was a risk to Charles following the assault, and the requirement for a safeguarding referral to be made.

14.7.2 It was also documented that Bill had a known history of substance misuse. This vulnerability was identified in an enhanced risk assessment completed whilst in hospital. There was no record that Bill was provided with information about substance misuse services or support in self-referring into those services. Substance misuse services were not discussed during the CPA meeting on 15 April 2020. [See 14.5.12]. The panel has identified this as an area of learning and made a relevant recommendation. [Recommendation 4].

14.8 Term 8

When, and in what way, were the subjects' wishes and feelings ascertained and considered? Were the subjects informed of options/choices to make informed decisions? Were they signposted to other agencies, and how accessible were these services to the subjects?

14.8.1 The panel was informed that Bill had been signposted to specialist services for support in relation to substance misuse. There were limited records as to what information Bill had been provided. Whilst the panel acknowledged that accessibility to services often requires an individual's consent, the panel agreed that consideration could have been undertaken by professionals to support Bill in making a self-referral. In reaching this decision, the panel was informed that a referral to drug and alcohol services can also be completed online by professionals – this may have been an opportune time to support with a referral as Bill was seeking advice and support from the GP.

14.8.2 Whilst the consultation discussed the social elements of Bill's substance misuse, there was no exploration as to the impact that this had on Charles, and an understanding of Bill's relationship with Charles. Bill had mentioned that Charles was in the early stages of dementia during a GP appointment in 2016: this was not explored further to establish if Bill had caring responsibilities which could have been assessed through a referral to the Local Authority.

14.8.3 Charles informed the police that he did not wish to pursue a complaint of assault against Bill. Whilst the police respected Charles's views, they did not signpost Charles to support agencies.

14.8.4 The mental health staff asked Charles if he was happy for Bill to return home upon discharge from hospital. Whilst Charles agreed to this, there was no record that any exploration was undertaken of the potential risks that this presented to Charles, or any referrals into services to support Charles with Bill living at home. There is no record that alternative living arrangements were discussed with Charles and/or Bill.

14.8.5 LSCFT informed the panel that it was expected practice at this time for Charles and Bill to have been provided with contact telephone numbers to allow them to seek additional support following discharge, and that clients and their families were encouraged to store relevant numbers within their mobile phones. Leaflets were not being handed out at this time due to restrictions in place as a result of the Covid-19 pandemic. Information gathered by the police following the murder of Charles, identified that Charles was seeking support and advice from a family member in the days prior to his murder. [See Section 13].

14.8.6 The Chair was informed by Charles's family that he did not own a mobile phone and did not have access to the internet at home and, therefore, would not have known how to obtain advice and support. The family told the Chair that Bill knew that Charles was unable to use a mobile phone and access the internet, and would therefore not have assisted him to access services via these methods. When seen by the Chair, Bill confirmed that his father did not have a mobile phone, did not use the internet, and described how his father would not 'have a clue' as to how to use a computer device to search the internet. Bill recalled that during one meeting after his discharge in April 2020, he was handed some leaflets, but stated that he had no recollection of what the leaflets were about or what he did with the leaflets after he returned home.

14.8.7 The Review Panel was informed that there is now a Mental Health Helpline[38] in place within Lancashire. The Wellbeing Helpline and Texting Service is a Freephone out-of-hours, person-centred listening environment for people requiring emotional support in relation to their own mental health, or that of someone they know. The Review Panel was informed that there has been extensive publicity across Lancashire to promote this service. The Review Panel has identified learning in relation to the

[38] https://www.lscft.nhs.uk/Mental-Health-Helpline

accessibility of information and made a relevant recommendation. [Recommendation 6].

14.9 Term 9

Did the agency have policies and procedures for Domestic Abuse and Safeguarding, and were these followed in this case? Has the review identified any gaps in these policies and procedures?

14.9.1 All agencies had in place policies and procedures for domestic abuse and safeguarding. These included policies in relation to familial abuse, domestic abuse in older people, and male victims. As has already been covered in this section, these were not followed in this case. This has been identified as learning by individual agencies and by the panel, and recommendations made.

14.10 Term 10

Were there any issues in relation to capacity or resources in your agency that affected its ability to provide services to Charles and Bill, or on your agency's ability to work effectively with other agencies? N.B. Please also consider any additional capacity/resource issues with agency contact during the Covid-19 pandemic.

14.10.1 Whilst in this event the case did not identify issues with capacity or resources within the GP surgery, the panel agreed it was relevant to add some context around how Covid-19 affected Primary Care during the timescales of the review. Primary care faced constant changes and new guidance that impacted on processes, as well as moving to virtual consultations in many instances (although face-to-face consultations continued throughout this period, as assessed based on need). There had been constant change of processes and guidance[39] from NHS England issued to GP practices.

14.10.2 During the period of Bill's admission, there were three clinical practitioners, and three registered mental health nurses absent from work due to Covid-19. In addition, five other wards at the hospital were experiencing Covid-

[39] https://www.england.nhs.uk/coronavirus/publication/preparedness-letters-for-general-practice/

19 related absence – this impacted on service delivery with the requirement to rely on temporary staffing and internal movement of staff across wards to ensure safe staffing. Despite the staffing levels, this should not have impacted on the capacity to make a safeguarding referral where risk was identified.

14.10.3 There was a delay in accessing an available AMHP to undertake the requested assessment following the murder of Charles. Whilst this is outside of the timescales of the review, it has been included here for record. The AMHP service was fully staffed with 4 AMHPs on duty for that day, as per service requirements; however, all AMHPs, including the duty co-ordinator, had been allocated and were undertaking assessments at the time of the request. There was significant and frequent communication from the police in relation to the delay. The assessment was commenced within three hours of receipt of the request.

14.10.4 No other agencies identified any issues in relation to capacity or resources.

14.11 Term 11

How did your agency take account of any racial, cultural, linguistic, faith or other diversity issues, when completing assessments and providing services to Charles and Bill?

14.11.1 Diversity is addressed under Section 11.

14.11.2 The review found no issues over the racial, cultural, linguistic, faith or diversity issues when assessments and services were provided to Charles and Bill.

14.11.3 All social care staff within Lancashire County Council are expected to provide an inclusive service that addresses all aspects of equality and diversity. Training and supervision is available to staff to ensure that this approach is maintained.

14.11.4 LSCFT staff include these within health and social needs assessments and person-centred care and treatment planning.

14.12 Term 12

What learning has emerged for your agency?

14.12.1 Blackburn with Darwen and East Lancashire Clinical Commissioning Group

- Learning around the wider context of domestic abuse in relation to familial domestic abuse.
- The importance of routine enquiry when a patient attends with an alleged assault, even for those that would not be perceived as an at-risk group.
- The importance of using routine enquiry within mental health reviews, both for discussing the victim of domestic abuse, but also the perpetrator.
- Flagging of records if it is raised someone has caring responsibilities, and the consideration of a referral for a carer's assessment.

14.12.2 Lancashire Constabulary

- Identifying victims and perpetrators of domestic abuse who may be presenting with mental health conditions, and ensuring they are referred to relevant support services.
- Recording and risk grading of incidents of vulnerability.

14.12.3 LSCFT

- Where risks are identified through enhanced risk assessment, they should have accompanying actions on the risk management plan.
- Routine enquiry should be completed in all cases where there is identified safeguarding concern around domestic abuse.
- Teams and practitioners should 'think family'. Actions should be clear in response to any identified risk. Where there are concerns or uncertainties, this should be escalated to line manager and discussed within individual and team supervision.
- Risk, health and social needs assessments should be completed through collaboration with service users, family and carers where applicable. When not possible, collateral information should be gathered and used to support risk assessment and management plans.

The Review Panel recognised the importance of Pendle CSP being provided updates in relation to the implementation of the recommendations and learning from LSCFT internal investigation – they have made a relevant recommendation. [Recommendation 5].

14.12.4 Lancashire County Council – Mental Health

- To ensure that AMHPs pass on the case information to community teams for follow up after Mental Health Act assessments, and refer cases for full Care Act and Social Care assessments where necessary.

14.12.5 In addition to individual agency learning, the DHR panel was informed that the following have been added to the Pendle Domestic Abuse action plan:

- Need to ensure the Pendle Domestic Abuse Forum supports the campaign work of Lancashire DA Strategic Board locally. This will include supporting the 'no excuse for abuse' campaign.
- Need to raise awareness to professionals and the community around the issue of domestic abuse within familial settings.
- To identify and work with Age UK (Lancashire) and other identified charities aimed at older people and carers.
- Undertake awareness activities related specifically to this issue, including updating websites as required.

The panel was informed that since progression on the learning identified, referrals for familial abuse have increased (Data received from police). There has also been a slight increase in referrals for the older age group.

14.12.6 The Review Panel was informed that further action has been taken to raise awareness of domestic abuse, including the use of social media to raise awareness of familial abuse and elder abuse. There will be a continuing use of social media in order to encourage those affected to access support, and those who are worried about someone they know to be alert to warning signs and to contact for help and advice.

14.13 Term 13

Are there any examples of outstanding or innovative practice arising from this case?

14.13.1 There were no examples of outstanding or innovative practice arising from this case.

14.14 Term 14

Does the learning in this review appear in other Domestic Homicide Reviews commissioned by Pendle Community Safety Partnership?

14.14.1 This is the first DHR that has been commissioned by Pendle Community Safety Partnership. However, the panel was aware of DHRs undertaken in neighbouring authorities where learning has been identified that is reflected in this case. That learning is attributed to agencies involved in this DHR who work within neighbouring authorities.

14.14.2 This learning includes:

- Routine enquiry within mental health consultations completed by GPs. (Rossendale 2019)[40]
- Recognition of domestic abuse when familial abuse occurs at times of a mental health crisis. (Blackpool 2021)[41]

15. CONCLUSIONS

15.1 Charles was murdered by his son, Bill. Charles had worked for all his adult life, and his family told the Chair that at the time of his murder, he was in the final stages of looking forward to his retirement.

15.2 In the month prior to the murder, Bill had assaulted Charles, and been admitted to hospital under Section 2 Mental Health Act 1983. The Review Panel was clear that this assault was domestic abuse. Whilst agencies recorded that Bill had assaulted Charles, it was not recognised as domestic

[40] https://www.rossendale.gov.uk/downloads/file/15675/case_of_marianne_exec_summary
[41] The Chair was also the Chair for this DHR which has similar themes of learning identified. This DHR was submitted to the Home Office in February 2021.

abuse, and therefore Charles was not signposted to services for support. The assault was not investigated as a criminal offence.

15.3 Whilst detained in hospital, Bill was reluctant to discuss the assault with health professionals, and his decision not to talk about the event was accepted and not challenged. Therefore, the extent of this incident was not fully understood by professionals.

15.4 The decision to discharge Bill back home to live with Charles was made without any consideration of the risk that Bill posed to Charles. Whilst Charles had been involved in some discussions on Bill returning to the family home, these discussions took place in the presence and hearing of Bill: they did not provide Charles with an opportunity to speak privately and raise any concerns on this decision, or allow him to disclose domestic abuse. The Review Panel was clear in their analysis that it was not appropriate to speak to a victim of domestic abuse in the presence and hearing of a perpetrator.

15.5 The Review Panel has identified several areas of learning in relation to the recognition of domestic abuse in older male victims, in particular where the perpetrator is a child of the victim. Further areas of learning include the accessibility to information for individuals who are concerned regarding a person's mental health, and the impact of the use of illicit drugs on a person's mental health.

15.6 Charles's family contributed invaluably to the review: by providing information, meeting with the Chair, and reviewing a draft version of the report. The Review Panel wish to extend their thanks to the family for this contribution.

16. LEARNING IDENTIFIED

16.1 Agencies Learning (taken directly from their IMRs)

16.1.1 Agency learning has been captured under Term 12.

16.2 The Domestic Homicide Review Panel's Learning (Arising from DHR panel discussions)

16.2.1 The DHR panel identified the following lessons. The panel did not repeat the lessons already identified by agencies at Term 12. Each lesson is preceded by a narrative which seeks to set the context within which the lesson sits. When a lesson leads to an action, a cross-reference is included within the header.

Learning 1 [Panel recommendation 1]
Narrative
Blackburn with Darwen and East Lancashire Clinical Commissioning has identified learning from previous DHRs in relation to the recording and use of 'routine enquiry', and created a template within electronic systems. This has been identified by the DHR panel as good practice.
Lesson
Talking about domestic abuse during routine health appointments provides victims of domestic abuse an opportunity to share any concerns, and gives professionals the opportunity to refer and signpost victims to support services.

Learning 2 [Panel recommendation 2]
Narrative
Domestic abuse can be presented in many ways, including being hidden or masked by other critical circumstances. Professionals need to ensure that when engaging with individuals at crisis point, they consider the wider context and impact on all who are affected by the situation, to identify cases of domestic abuse.
Lesson
By identifying incidents as domestic abuse, it allows for professionals to complete a risk assessment, and to determine the level of risk and requirement for agency involvement, including referral and signposting to services.

Learning 3 [Panel recommendation 3]
Narrative
People's presentation at a point of crisis may be linked to other factors in their life, which require support from other agencies. Professionals need to be able to recognise these incidents and ensure that relevant referrals are completed.

Lesson
Understanding the circumstances surrounding incidents when individuals are presenting at a time of crisis, will enable appropriate referrals and signposting to agencies to be undertaken.

Learning 4 [Panel recommendation 4]
Narrative
The use of illicit drugs can trigger mental health problems or make existing mental health problems worse.
Lesson
Information on the effects of illicit drug use, and the impact that this could have on an individual's mental health, should be accessible to practitioners and the community.

Learning 5 [Panel recommendation 6]
Narrative
The review identified that agencies should not just rely on individuals accessing information via the internet: information should be available in a variety of formats so that it is accessible to all members of the community.
Lesson
All members of the community should be able to access information, in a range of formats, to allow them to gather information on the availability of agencies and support services that can respond to concerns regarding an individual's mental health.

17. RECOMMENDATIONS

17.1 Panel Recommendations[42]

[42] Recommendations 1 – 4 were agreed by Pendle Community Safety Partnership on 19 July 2021.

Number	Recommendation
1	That Blackburn with Darwen and East Lancashire Clinical Commissioning Group provides updates to Pendle Community Safety Partnership on the rollout of the routine enquiry template within GP practices.
2	That all agencies[43] provide reassurances and evidence to Pendle Community Safety Partnership that the learning from this case, in relation to the recognition of domestic abuse including the identification of domestic abuse in males and the older generation, has been disseminated.
3	That Lancashire Constabulary provides an update to Pendle Community Safety Partnership on the action plan and learning from the recent DHR concluded in Blackpool in 2021.
4	That Pendle Community Safety Partnership ensures information is available on the effect and impact of using illicit drugs.
The following recommendations were agreed by the panel at the conclusion of the DHR process: they are in addition to the above recommendations which were agreed and accepted by Pendle Community Safety Partnership in July 2021.	
5	That Lancashire and South Cumbria NHS Foundation Trust provides progress updates to Pendle Community Safety Partnership regarding their internal investigation action plan – these will be at 3, 6 and 9 months, with a presentation to the CSP at the 12 months' stage to assure the CSP of progress, and inform of any ongoing challenges.
6	That Pendle Community Safety Partnership ensures that access to information on support services which can respond to concerns regarding an individual's mental health, whether the concerns are in relation to the individual's own mental health or for someone they know, is available for all members of the community.

[43] This is the Integrated Care Board which replaced the CCG on 1 July 2022.

Appendix A

Definition of Domestic Abuse

Domestic violence and abuse: new definition

The cross-government definition of domestic violence and abuse is:
any incident or pattern of incidents of controlling, coercive, 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. The abuse can encompass, but is not limited to:

- psychological
- physical
- sexual
- financial
- emotional

Controlling behaviour

Controlling behaviour is a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.

Coercive behaviour

Coercive behaviour is an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim. This is not a legal definition.

Appendix B

Controlling or Coercive Behaviour in an Intimate or Family Relationship

A Selected Extract from Statutory Guidance Framework[44]

- The Serious Crime Act 2015 [the 2015 Act] received royal assent on 3 March 2015. The Act creates a new offence of controlling or coercive behaviour in intimate or familial relationships [section 76]. The new offence closes a gap in the law around patterns of controlling or coercive behaviour in an ongoing relationship between intimate partners or family members. The offence carries a maximum sentence of 5 years' imprisonment, a fine or both.
- Controlling or coercive behaviour does not relate to a single incident, it is a purposeful pattern of behaviour which takes place over time for one individual to exert power, control or coercion over another.
- This offence is constituted by behaviour on the part of the perpetrator which takes place "repeatedly or continuously". The victim and alleged perpetrator must be "personally connected" at the time the behaviour takes place. The behaviour must have had a "serious effect" on the victim, meaning that it has caused the victim to fear violence will be used against them on "at least two occasions", or it has had a "substantial adverse effect on the victims' day to day activities". The alleged perpetrator must have known that their behaviour would have a serious effect on the victim, or the behaviour must have been such that he or she "ought to have known" it would have that effect.

Types of behaviour

The types of behaviour associated with coercion or control may or may not constitute a criminal offence. It is important to remember that the presence of controlling or coercive behaviour does not mean that no other offence has been committed or cannot be charged. However, the perpetrator may limit space for action and exhibit a story of ownership and entitlement over the victim. Such behaviours might include:

- isolating a person from their friends and family;
- depriving them of their basic needs;
- monitoring their time;
- monitoring a person via online communication tools or using spyware;
- taking control over aspects of their everyday life, such as where they can go, who they can see, what to wear and when they can sleep;
- depriving them of access to support services, such as specialist support or medical services;
- repeatedly putting them down such as telling them they are worthless;

[44] Controlling or Coercive Behaviour in an Intimate or Family Relationship Statutory Guidance Framework. Home Office 2015

- enforcing rules and activity which humiliate, degrade or dehumanise the victim;
- forcing the victim to take part in criminal activity such as shoplifting, neglect or abuse of Children's to encourage self-blame and prevent disclosure to authorities;
- financial abuse including control of finances, such as only allowing a person a punitive allowance;
- threats to hurt or kill;
- threats to a child;
- threats to reveal or publish private information [e.g. threatening to 'out' someone].
- assault;
- criminal damage [such as destruction of household goods];
- rape;
- preventing a person from having access to transport or from working.

This is not an exhaustive list

Appendix C

EVENTS TABLE

The following table contains a summary of important events that will help with the context of the Domestic Homicide Review. It is drawn up from material provided by the agencies that contributed to the review.

Events Table	
Date	**Event – Pre ToR**
1980	Entry in Charles's GP records of hallucinations over 4 days.
2002	Charles attended hospital with facial injuries.
2003	Bill attended GP with history of behavioural problems for past two years. Bill was 15 years old. History of cannabis use for 6-12 months.
2011	Bill attended GP with history of low mood and thoughts of deliberate self-harm. Medication prescribed and referral made. Bill seen by Psychiatry and referred for counselling for bereavement support. Further review with GP and medication recommenced. Bill discharged after two appointments not attended.
2016	Bill seen by GP on five occasions for low mood. Initially, Bill was commenced on medication and advised to self-refer to mental health services. Bill's compliance with medication varied and a pattern of commencing and stopping medication was seen during the year.
2016	Bill arrested for assault on bus passenger.
	Events within ToR
20.01.19	Charles attended hospital with facial injury reported to be from a fall. Left before treatment.
20.01.19	Police received call from family member reporting Charles missing.
22.01.19	Bill telephoned police to report assault on his father. Incident occurred on 20 January 2019. The crime was not detected.
30.01.19	Charles seen by GP and referred for CT scan following injury sustained on 20 January 2019.
11.02.19	Charles attended GP practice to request a further fit note.
06.03.19	GP sent a task to arrange a review with Charles of CT scan.
08.03.19 – 13.03.19	GP surgery attempted to contact Charles on three occasions.
22.03.19	GP surgery sent letter to Charles.
01.04.19	Charles seen by GP for review of CT scan.
10.06.19	Bill attended hospital with back injury.
07.08.19	Bill attended hospital with head injury due to assault.
15.08.19	Bill seen by GP following hospital attendance on 7 August 2019.
09.01.20	Charles did not attend appointment for smoking cessation advice.
13.01.20	Charles seen at GP surgery for physical health concern.

27.01.20	Bill seen by GP with concerns around cocaine and cannabis dependence. Reported to have used cannabis since the age of 12 and has recently started taking cocaine.
09.04.20	Charles attended at police station and reported he had been assaulted by Bill. Bill was detained under Section 136 Mental Health Act. Bill was taken to a mental health suite at hospital and later detained under Section 2 Mental Health Act and admitted to hospital.
11.04.20	Clinical entry reflecting that safeguarding referral may be required due to violence and aggression towards Charles prior to admission.
12.04.20	Hospital staff attempted to contact Charles.
14.04.20	Face-to-face assessment conducted with Bill.
15.04.20	Hospital staff contacted Bill's mother. Care Programme Approach (CPA) review completed.
19.04.20	Hospital staff contacted Charles.
20.04.20	Bill discharged to home address. 48-hour follow-up was arranged with Pennine East Crisis team
21.04.20	Bill attended 48-hour follow-up. Charles was present throughout appointment.
22.04.20	Bill discharged from Home Treatment Team.
23.04.20	Bill attended follow-up appointment with Mental Health Unit. Discharged back to care of GP.
30.04.20	GP surgery attempted to contact Bill to review medication. (2 attempts made).
May 2020	Charles was found deceased. Bill was arrested and charged with murder.