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EAST SUSSEX SAFER COMMUNITIES PARTNERSHIP

DOMESTIC HOMICIDE REVIEW

Overview Report into the Death of a Woman in April 2018

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Abbreviations

CCR: Coordinated Community Response
CCG: Clinical Commissioning Group
CPN: Community Psychiatric Nurse
CRC: Community Rehabilitation Company
CSP: Community Safety Partnership
DASH: Domestic Abuse, Stalking and Harassment and Honour-based violence risk identification, assessment and management model
DHR: Domestic Homicide Review
DVPO/DVPN: Domestic Violence Protection Order/Domestic Violence Protection Notice
GAD: general anxiety disorder
GP: General Practitioner
HMPPS: Her Majesty's Prison and Probation Services
IAPT: Improving Access to Psychological Therapies programme
IDVA: Independent Domestic Violence Advisor
IMR: Individual Management Review – reports submitted to review by agencies
MARAC: Multi-Agency Risk Assessment Conference
ONS: Office for National Statistics
PCLDS: Police and Court Liaison and Diversion Service
PHQ: Patient Health Questionnaire
RAR: Rehabilitation Activity Requirement
SCARF: Single Combined Assessment of Risk
Standing Together: Standing Together Against Domestic Abuse
VAAR: Vulnerable Adult at Risk assessment

Glossary

Matricide: the killing of a mother
Patricide: the killing of a parent or other near relative
GAD-**7** is a screening tool used in primary care and mental health settings to measure the severity of symptoms of anxiety
PHQ 9: is a tool used in health settings to monitor the severity of depression and the response to treatment.
Single Combined Assessment of Risk Form (SCARF) Within East Sussex, this assessment amalgamates risk assessments for vulnerable people, including Domestic Abuse, Stalking and Harassment and Honour Base Abuse (DASH) and Vulnerable Adult at Risk (VAAR). SCARFs are triaged by the MASH and shared with partner agencies as appropriate, helping partners build a complete picture and identify any concerns or emerging problems which may require intervention.

Preface

Members of the review panel offer their deepest sympathy to the family and to all who have been affected by the victim's death.

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

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1. Introduction

1.1 Background

1.1.1 This review concerns the homicide of a fifty-one-year-old woman by her twenty-two-year-old son. Her son was found guilty of manslaughter with diminished responsibility.

1.2 Aim and Purpose of a domestic homicide review

1.2.1 Domestic Homicide Reviews (DHR) came into force on the 13th April 2011. They were established on a statutory basis under Section 9(3) of the Domestic Violence, Crime and Victims Act (2004). The Act states that a DHR should be a review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by (a) a person to whom they were related or with whom they were or had been in an intimate personal relationship or (b) member of the same household; with a view to identifying the lessons to be learnt from the death.

1.2.2 The purpose of a DHR is to:

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

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

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

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

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

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

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

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

1.3. Timescales

1.3.1. The homicide occurred in April 2018 and the decision to undertake a review was made by the Chair of East Sussex Safer Communities Partnership in consultation with affected agencies. The Home Office was notified on 15/05/2018.

1.3.2. The review commenced in April 2019 after criminal proceedings had completed in November 2018, and after a short delay arising from changes in local commissioning arrangements for domestic abuse and domestic homicide. The review was delayed in its conclusion as a result of national arrangements to contain the spread of the Covid-19 pandemic. Nonetheless, the panel met four times. All panel meetings were minuted and all actions agreed for the panel have been tracked and completed.

1.3.3. The panel considered and agreed the draft Overview Report in April 2020, and the final draft Overview Report was endorsed by the Community Safety Partnership in November 2020 after providing the victim's family the opportunity to comment, prior to submission to the Home Office.

1.4. Confidentiality

1.4.1 This Overview Report has been anonymised in accordance with statutory guidance. In order to protect the identity of individuals affected, the bereaved family were given the opportunity to provide a pseudonym for the homicide victim but chose to use the terms 'victim' instead.

1.4.2 Whilst the details of each review remain confidential, available only to participating professionals and their direct line management, the report has sought to extract sufficient detail from the family's narrative for the lessons and recommendations to be understood, whilst balancing this need for confidentiality.

2. Terms of Reference

2.1. Methodology

2.1.1. The review followed the methodology required by the Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews (Home Office, 2016). Twenty-three agencies were notified of the death and were asked to examine their records to establish if they had provided any services to the victim or the perpetrator and to secure records if there had been any involvement. Sixteen agencies, in both East Sussex and London, were found to have relevant contact with the victim and her son. Seven local agencies had had no relevant contact.

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

2.1.3. Sussex Police provided the findings from the criminal investigation and provided details of the family who were to be invited to engage with the review.

2.1.4. The terms of reference for the review were drawn up by the Independent Chair together with the review panel, incorporating key lines of enquiry and specific questions for individual agencies where necessary. It was identified that nine agencies were to provide Individual Management Reviews (IMRs) and chronologies analysing their involvement and a further seven agencies were to provide information reports due to the brevity of their involvement. Briefings were made available for IMR authors by the Independent Chair in order to support report authors in their task and maintain the focus of the key lines of enquiry.

2.1.5. All reports were written by authors who were independent of the delivery of services provided. Wherever possible, report authors presented their findings to the review panel in person and, where necessary, were asked to respond to further questions. The individual agency reports concluded with

recommendations for improving their own agency policy and practice responses in the future and informed the multi-agency and thematic recommendations which followed.

2.1.6. The Independent Chair authored the Overview Report after consultation with the victim's family, and each draft was discussed and endorsed by the review panel before submission to the Community Safety Partnership.

2.2. Involvement of Family and Friends

2.2.1. Family members were notified through the police and provided with letters and explanatory leaflets from the Home Office as well as leaflets concerning specialist support services, Advocacy After Fatal Domestic Abuse and Victim Support. Two members of the family agreed to engage with the review, one of whom was supported by the Victim Support Homicide Service and the other through a solicitor.

2.2.2. The Independent Chair went on to meet with one member of the family and both family members were provided with the opportunity to comment on the draft terms of reference and their comments have been incorporated into the key lines of enquiry for the review. These included questions concerning the apparently sudden deterioration of the perpetrator's mental health in the day before the manslaughter; previous indicators of the perpetrator's schizophrenia and thresholds for receiving services.

2.2.3. Bereaved family members were updated on the progress of the review and given the opportunity to comment on the draft overview report before it was endorsed by the Community Safety Partnership.

2.2.4. Consideration was given to engagement with the victim's close friends who were contacted through the family and with the victim's ex-boyfriend and work colleagues who were contacted directly. However, they did not return contact and were deemed to have declined engagement.

2.2.5. Following consultation with his psychiatrist, the perpetrator was invited to engage with the review, but he did not return contact and was therefore also deemed to have declined engagement.

2.3. Independent Chair and Author

2.3.1 The Independent Chair and Author is Paula Harding, an Associate Chair with the charity, Standing Together Against Domestic Abuse. She has over twenty-five years' experience of working in domestic abuse with both senior local authority management and specialist domestic abuse sector experience. For more than ten of those years she was a local authority strategic and commissioning lead for domestic abuse and violence against women in Birmingham and has been an independent chair and author of domestic homicide and safeguarding adult reviews since 2016. She completed an M.A. (Birmingham) in Equalities and Social Policy in 1997, focusing on domestic abuse and social welfare, and is a regular contributor to conferences, national consultations and academic research. She completed the OCR certificated training funded by the Home Office for *Independent Chairs of Domestic Homicide Reviews* in 2013. She has also completed the on-line training provided by the Home Office, *Conducting a Homicide Review,*[1] as well as undertaken accredited training on the Significant Incident Learning Process and Learning Disability Mortality Reviews.

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

2.3.3 Beyond domestic homicide reviews, the Chair has no connection with East Sussex Safer Communities Partnership or any of the agencies involved in this case.

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

2.4. Members of the Review Panel

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

2.4.2 Wider matters of diversity and vulnerability were considered when agreeing panel membership. Care Grow Live (CGL) provides the local domestic abuse service and therefore brought particular expertise on domestic abuse and the 'victim's perspective' to the panel. CGL also provide the local substance misuse services and enabled a further panel member to provide expertise on drugs and alcohol.

2.4.3 The review panel members were:

Name	Role/Organisation
Paula Harding	Independent Chair
Alison Cooke	Named Nurse Adult Safeguarding, Sussex Community NHS Foundation Trust
Bryan Lynch	Deputy Director of Social Work, Sussex Partnership NHS Foundation Trust
Domenica Basini	Assistant Director for Safeguarding and Quality, NHS England
Gillian Field	Designated Nurse Safeguarding Adults, Sussex Clinical Commissioning Groups
Jane Wooderson	Detective Sergeant, Safeguarding Review Team, Sussex Police
Karen Davies	Matron Safeguarding Adults, Maidstone and Tunbridge Wells NHS Trust
Karen Perrier	Client Service Manager, Money Advice Plus
Lee Whitmore	Assistant Chief Probation Officer, Kent Surrey and Sussex Community Rehabilitation Company
Leigh Prudente	Head of Service, East Sussex Adult Social Care
Lindsay Adams	Strategic Commissioner, East Sussex County Council
Michaela Richards	Director of Operations South-East, Change, Grow, Live
Debbie King	Head of Service, The Portal (multi-agency domestic and sexual abuse and Independent Domestic Violence Advisor Service), Change Grow Live

Natasha Gamble	Strategy & Partnership Officer for Domestic, Sexual Abuse and Violence, Joint Domestic, Sexual Violence & Abuse and Violence against Women & Girls (VAWG) Unit Brighton & Hove and East Sussex

2.5. Time period

2.5.1. The panel agreed that the review should focus on the contact that agencies had with the victim and her son during the period from September 2016, when her son returned to the UK, until the victim's death in April 2018. Information about earlier times was included for contextual information only.

2.6. Key Lines of Enquiry

2.6.1. The review sought to address both the 'circumstances of particular concern' set out in the Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews (2016) and the following specific issues identified in this particular case:

- Analyse key episodes in agencies' response including the nature of assessments, decision making and responses and whether they met the expected standards of practice and procedures.
- Analyse how agencies engaged with the perpetrator in respect of assessments, services or supervision orders and responded when they were unable to engage.
- How was the perpetrator's alcohol and drug use understood in relation to his care needs and risk to himself and others?
- Analyse the opportunity for agencies to routinely enquire, identify, assess and respond to domestic abuse or public protection risk, threat and needs.
- Analyse how organisations accessed or worked with specialist domestic abuse and substance misuse agencies in this case.
- Analyse any delays in providing a service to the victim or perpetrator.
- Was the victim identified as a formal or informal carer? How did agencies involve the victim in assessments of her son and what opportunities were there to have a formal or informal carer's assessment about her needs and responsibilities?

- How robust was multi-agency working? Analyse how effectively agencies worked together to share information, assess, make decisions and respond to the risks, threats and needs of the victim, perpetrator and wider family. Were joint working protocols themselves robust?
- How well did agencies know the terms of the restraining/non-molestation order, anti-social behaviour injunction and the suspended sentence order, and respond to any perceived breaches of these terms?
- Analyse the policies, procedures, supervision, support and training available to the agencies involved in domestic abuse issues, including familial abuse.
- To outline each agency process and practice in generating or responding to a Single Agency Combined Assessment of Risk (SCARF).

2.7. Individual Reports

2.7.1. Individual management reviews and chronologies were requested from the following organisations:

- General Practitioners
- Kent and Medway Partnership Trust
- Kent, Surrey & Sussex Community Rehabilitation Company
- London Community Rehabilitation Company
- Metropolitan Police
- Sussex Partnership NHS Foundation Trust
- Sussex Police

2.7.2. The following agencies had less involvement and were asked to provide briefer reports and chronologies:

- East Sussex County Council Adult Social Care and Health
- British Transport Police
- Camden and Islington NHS Foundation Trust
- Sussex Community NHS Foundation Trust
- Kent Police
- Maidstone and Tunbridge Wells NHS Trust
- Priory Hospital
- Surrey Police

- University College Hospital London

2.7.3. GPs were asked to specifically consider:

- Where was the perpetrator registered with primary care and what were the periods of his registration?
- How the perpetrator disclosed his substance misuse and what opportunities were there to engage him in treatment?
- How the perpetrator's mental health was understood and whether secondary mental health services were engaged in his diagnosis or treatment?
- Whether the victim raised concerns about her son and how these concerns were responded to.
- Whether the victim disclosed violence and abuse from her son or, if not, whether there were opportunities to make further or routine enquiry with her?
- Whether the GP practices have robust staff training, procedures and pathways for clinical or routine enquiry and responses to domestic violence and abuse?

2.8. Agencies without contact

2.8.1. The following agencies were contacted but confirmed that the victim or perpetrator were not known to them:

- East Sussex Drug and Alcohol Service (STAR)
- East Sussex Healthcare NHS Trust (community children's health)
- East Sussex Multi Agency Risk Assessment Conference (MARAC)
- Optivo Housing Association
- Refuge (domestic abuse service)
- SWIFT Specialist Family Services
- Wealden District Council (housing services)

2.9. Definitions

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

> *"Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or*

sexuality. This can encompass but is not limited to the following types of abuse:

- *psychological*
- *physical*
- *sexual*
- *financial*
- *emotional*

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

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

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

2.9.3. Although the perpetrator's abuse of his mother falls under the government's definition of domestic violence and abuse, there are additional dimensions of child to parent abuse, known variously as adolescent-to-parent abuse and parental abuse, and there is currently no legal definition to cover this particular form of abuse. In this document it will be referred to as child-to-parent abuse, whilst recognising that this does not helpfully reflect the gendered nature of the abuse of a mother nor reflect the older age of the perpetrator.

2.10. Parallel Reviews

2.10.1. In addition to criminal proceedings, Sussex Partnership NHS Trust has undertaken an internal review within the Serious Incident Reporting Framework that was in place at the time (NHS England,2015) and this review was shared with the review panel. Relevant information from a Serious Further Offence Review (HM Prison and Probation Service, 2014) undertaken

by London Community Rehabilitation Company on behalf of the probation services involved, has been included within their Individual Management Review.

2.11. Equality and Diversity

2.11.1. The review gave due consideration to each of the nine protected characteristics under Section 149 of the Equality Act 2010[2], as well as to wider matters of vulnerability for both the victim and her son.

2.11.2. The victim was a fifty-one-year-old, white, British woman who was the mother of two grown-up children and had been divorced for eighteen years at the time of the homicide. She owned the home in which she lived in a relatively affluent area of East Sussex. She had no known disabilities and her faith and sexuality were not known.

2.11.3. Her son shared his mother's ethnicity and was aged twenty-two at the time of the homicide. He experienced anxiety, depression and problematic substance use and, when intoxicated, had previously self-harmed and taken overdoses. Beyond his mental health, no other matters of disability were known. He suffered from arthritis in his hands, which, whilst not of the degree to be considered a disability, had curtailed his plans for a musical career. Matters of faith and sexuality were not known.

2.11.4. Domestic abuse and domestic homicide are considered to be, most often, gendered crimes (Stark, 2007). In the three years preceding the victim's death, the majority (74 per cent) of victims of domestic homicides in England and Wales were female (ONS, 2019). Moreover, in the year before the victim died, over 7 per cent of women killed within the context of domestic abuse were killed by their sons: this was double the number of the previous year (Femicide Census, 2017, p.26).[3] In this way, the significance of gendered violence should always be considered in a homicide review. It was noted that the review was not made aware of the perpetrator's relationship with other women and could not therefore consider his behaviour within this wider context.

2.11.5. Although child-to-parent violence is under-researched, a recent analysis of reported cases of child-to-parent abuse (n=1862) found that this is also

[2] The nine protected characteristics under the Equality Act 2010 are age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex and sexual orientation

[3] This excludes from the Femicide Census, women killed by terrorism, strangers, friends or neighbours

predominantly a gendered phenomenon: 87 per cent of perpetrators were male; 77 per cent of victims were female; and 66 per cent of cases involved a son-to-mother relationship (Miles and Condry, 2014:271). The review therefore considered how the mother-son relationship impacted upon agencies' responses to domestic abuse.

2.11.6. The relative affluence of the family was raised as a possible unconscious bias during the course of the review in so far as it may have masked economic abuse or impacted upon a sense of entitlement from the victim's son. Therefore, issues of class, sex and gendered violence and the perpetrator's mental health, are explored throughout this report.

2.11.7. The Review applied an intersectional framework in order to understand the lived experiences of both victim and perpetrator. This means to think of each characteristic of an individual as inextricably linked with all of the other characteristics in order to fully understand an individual's journey and experience with local services and within their community

2.12. Dissemination

2.12.1. The following individuals and organisations will receive copies of this review:

- The victim's family
- Agencies involved in this review
- East Sussex Community Safety Partnership and its agencies
- Sussex Police and Crime Commissioner
- Standing Together Against Domestic Abuse Domestic Homicide Review Team

3. Background Information

3.1. Persons involved in this review

3.1.1. The victim was a fifty-one-year-old woman who divorced whilst her two children were young. The victim and her wider family were relatively affluent. She worked as the manager of a health and beauty shop in a nearby town and owned her own home in a semi-rural location on the outskirts of a prosperous Sussex town.

3.1.2. Her son, the perpetrator, who was aged twenty-two at the time of the homicide, is the eldest of the victim's two children. The victim's younger daughter was studying and living away from home at university when the homicide took place.

3.1.3. The victim's mother and stepfather lived some distance away, whilst her father lived abroad. The children retained contact with their father and stepmother who lived approximately thirty miles away from their mother's home.

3.2. The Homicide

3.2.1. The perpetrator had been staying with his mother for four days despite being subject to a restraining order to stay away from her. Unable to contact her mother, the victim's daughter raised concerns with the police. The victim was found deceased in her bedroom. She had been killed in her bed and died from a single stab wound to the chest.

3.2.2. The perpetrator pleaded guilty to manslaughter by virtue of diminished responsibility. The criminal investigation found that he kept a diary which offered significant insights into his state of mind during the period leading up to the offence and within his sentencing remarks, the judge expressed concern, "The risk of a further psychotic episode remains, in particular, if you were to use illicit substances again". The perpetrator was therefore sentenced to life imprisonment with a minimum term of two years alongside a hospital order, under section 45a of Mental Health Act 1983. The Court of Appeal later quashed the original hospital order and replaced it with a Hospital Order under Section 37 with a Restriction Order under Section 41. This change meant that the perpetrator would not be sent back to prison when he recovers from his mental illness but released into the community. If the perpetrator is granted a conditional discharge by the Secretary of State, he will be supervised by a psychiatrist and social worker in the community, who will report to the Mental Health Casework Section of the MoJ and may recommend recall to hospital if his mental health deteriorates and he is assessed as no longer safe to be in the community

4. Sequence of Events

4.1 The following sequence of events refers mainly to agency contact with the victim's son as the victim herself had little contact with agencies beyond

reports to the police and interaction with agencies providing services to her son.

The perpetrator returned from the USA

4.2. After attending private school and studying electric guitar, the victim's son went to music college in America which was financed by his maternal grandparents. Whilst there, he developed arthritis in his hands which was going to curtail his plans for a promising musical career. He experienced problems with drug use, dropped out of his course, and was admitted to an in-patient psychiatric hospital for one night in May 2015. He had overdosed on a mixture of alcohol and benzodiazepine, which is a drug commonly used to treat anxiety and panic attacks.

4.3. In September 2015, he returned home to live with his mother and younger sister, but his mother continued to be worried about his mental health. Having been shy as a child, family members considered that he had developed quite extreme social anxiety.

4.4. In November 2015, the victim took her son to the Tunbridge Wells Hospital Emergency Department as she was worried that he had become depressed and suicidal. However, he walked out in the early hours of the morning, before he had been fully assessed. The hospital contacted Kent Police to report that he was missing and that he was potentially psychotic and suicidal.

4.5. Kent Police undertook immediate action to locate the perpetrator as a missing person which included deploying six patrol cars, a dog handler, and gaining permission to request assistance from the National Police Air Service. The Kent Police Patrol Sergeant requested that the perpetrator be returned to hospital and liaised with Sussex Police. They also established from the victim that her daughter and her daughter's boyfriend were at home should he return there.

4.6. The perpetrator was located by Sussex Police two hours later and explained to them that he was walking home and that, although he felt tired, he was absolutely fine after clearing his head and listening to his music. Officers asked him whether he felt suicidal or might harm himself, which he denied. They observed him to be quiet. He did not smell of alcohol or present any issues or exhibit any behaviour that gave the officers any concern for his immediate wellbeing. As they did not consider that there were sufficient grounds to take him back to hospital against his will, they tried to contact his

mother. However, as the perpetrator was willing to accept a lift, he was returned home where his sister, who was seventeen at the time, was waiting with her boyfriend. Police officers were deployed to the hospital to let his mother know. She had been waiting at the hospital and it was explained why they did not consider that they had powers to detain him, and she therefore returned home.

4.7. Nonetheless, an urgent referral was made by Sussex Police to mental health services, using the local, multi-agency Single Combined Assessment of Risk Form (SCARF). In addition, the Vulnerable Adult at Risk (VAAR) section was completed and forwarded to Health and Social Care Connect, a multi-agency points of access for adult social care and community healthcare services in the area. Likewise, the Liaison Psychiatric Team (Kent and Medway Partnership Trust) at the hospital made an urgent referral to the local mental health team, requesting that he be assessed due to concerns about his risk to self and others, as well as some untreated burns.

4.8. In response, practitioners from the Assessment and Treatment Service of Sussex Partnership NHS Foundation Trust, which provided local mental health services, contacted the victim the same day. She told them that she was concerned that her son needed to be seen soon. They also spoke with the perpetrator on the phone. He was assessed by a community psychiatric nurse (CPN) two days later.

4.9. At the assessment, the perpetrator described having a strained relationship with both of his parents and described their difficulties mainly stemming from his financial situation and his substance use. He admitted using cocaine and cannabis regularly, alongside alcohol. He denied any health problems except for the burns, which he attributed to a barbecue accident, and the arthritis in his hands. The decision was made by practitioners to offer him a further assessment to identify if there was an underlying psychosis, as he appeared to be guarded and was displaying inappropriate emotions. They noted that he appeared to lack insight into his mental state, and he denied that his family were expressing concerns about his mental state.

4.10. The assessing CPN contacted the Early Intervention in Psychosis team to enquire as to whether they could attend the next assessment appointment with him. They suggested that if the CPN had further concerns following the second assessment that the young man should be referred, which was normal practice. In the meantime, the perpetrator attended his GP appointment and was prescribed medication to assist with his anxiety, on the recommendation of the mental health service.

4.11. Adult Social Care responded to the SCARF referral on the day that it was received and attempted to contact the victim by phone over the following three days in order to offer a carer's assessment. When they received no reply, they sent her a letter inviting contact, which was not forthcoming.

4.12. After this, family members described how the perpetrator started to drink more heavily and began stealing to pay for more alcohol.

Assault of the victim's boyfriend

4.13. Within the week of his first attendance at hospital, the victim phoned the police after her son had attempted to punch and headbutt her boyfriend when they had refused to give him money for cigarettes. She herself was being pushed by her son whilst making the call, and he was said to have been heavily intoxicated.

4.14. The victim told police officers that her son's condition had not been completely diagnosed but that it was suspected that he had a personality disorder or was a "manic depressive" (suffering from bi-polar disorder). She advised that he was due a further appointment later that week. A Domestic Abuse, Stalking, and 'Honour' Based Abuse Risk Assessment Checklist (DASH) was undertaken with the victim, and she was assessed as facing standard risk. Whilst her son exhibited worrying behaviour, the incident was described as a 'minor scuffle' by the Police. Although it was her partner that had been the target in this incident, the police identified the victim's vulnerability and completed a DASH risk assessment with her, allowing her to disclose how she felt. She reported feeling frightened of what her son was capable of doing, given his state of mind. The victim's partner did not want to support a prosecution, but the police made a (SCARF) referral to Health and Social Care Connect and gave advice on the support that other agencies could provide. They also took the perpetrator to his father and stepmother's address, approximately thirty miles away.

Mental health assessments

4.15. On the following day, the perpetrator's stepmother contacted mental health services to update them. As he was now staying in another area, the Crisis Resolution Home Treatment Team in his new catchment agreed to look into the situation. His stepmother indicated that his father would not agree for

his son to be admitted to a mental health unit but felt that he would agree to an assessment if necessary. All relevant teams were updated of progress and the potential for assessment, and the perpetrator's stepmother was advised to take him to the Emergency Department should his condition deteriorate.

4.16. On the next day, the perpetrator was accompanied by his stepmother to the Urgent Care Treatment Centre reporting that his anxiety and depression had been worsening over the last few days. His stepmother had taken him to be assessed as she was having to return to work herself and the victim had said that he could only return to her home if a mental health professional felt it was safe for him to do so. He was assessed by mental health services from Sussex Partnership who considered that he did not present with depressive or anxiety symptoms. However, a diagnostic assessment was recommended due to his recent behaviour. He was also strongly advised to avoid alcohol and cannabis as they could trigger a change in his behaviour towards others and affect his mood.

4.17. Over the next two months, the perpetrator received a further three assessments and spoke regularly with his CPN. By the second assessment, he reported feeling much better, and presented as much warmer and able to engage. He seemed relaxed and there was no evidence of thought or perceptual disorder, no suicidal thoughts or plans, and his sleep and appetite were good. By the third assessment, he reported that his relationship with his mother and sister had improved. During this time, the victim took opportunities to speak directly with mental health practitioners about her ongoing concerns about his mental health.

4.18. By December 2015, however, the perpetrator reported an increase in his alcohol consumption and asked how he could access rehabilitation. He said that he was not experiencing hangovers and he had no symptoms of withdrawal. He was given information about the substance misuse service STAR (East Sussex Drug and Alcohol Recovery Service) and the effects that alcohol would have on his mood and mental state were explained. He agreed that he was maintaining a gradual recovery from his initial crisis and that alcohol and substance use had played a part in the deterioration of his mental state. Indeed, it was considered that he may have still been under the influence of residual substances (alcohol or drugs) in his system when he was first assessed.

4.19. Having been prescribed antidepressants by his GP, by January 2016 he reported noticing some benefits. He reported to the CPN that he had not

used substances or alcohol since the previous appointment but had decided not to contact the substance misuse service. Instead, he was going to focus on getting himself a job. However, within six weeks, the perpetrator's drinking had re-emerged, and he had been caught shoplifting alcohol. He missed an appointment with the consultant psychiatrist, but his mother attended and used the opportunity to discuss her concerns regarding her son's mental health.

4.20. During the perpetrator's meetings with the CPN, he explored the reasons for his drinking in some detail and he reported that he tended to drink to suppress anxiety and feelings of regret around missed opportunities. Methods for managing anxiety were discussed with him and he spoke about his long-term plans to live abroad. He said that he hoped to find a job so that he could save money to go to Amsterdam to work and have access to legal cannabis.

4.21. In March 2016, the perpetrator was discharged from acute mental health services back to the care of his GP as there was no evidence to support that he had a severe and enduring mental health problem. It was considered that his primary issue was around anxiety and his use of alcohol and substances to manage this. He was encouraged again to attend the substance misuse service, but he was reluctant to do so as he did not accept that he had a substance misuse problem.

Suspected of Criminal Damage and Gambling

4.22. In April 2016, Sussex Police received a 999 call from the victim stating that her son was 'kicking off outside'. She described how he was not allowed into the house and was trying to gain entry. That day she had discovered that he had attempted to fraudulently use her credit cards on an online gambling site, so she had packed his bags with his belongings and asked him to leave.

4.23. She spoke to the officers and provided the background history of her son's mental health deterioration, which she believed was due to his continued use of cannabis. She added that after the last incident he had returned to stay with her and, as he was not engaging with mental health support agencies, it was putting a strain on the family home.

4.24. The incident was recorded as domestic abuse related criminal damage due to the front door wooden frame having been splintered after the perpetrator had kicked the door. The victim did not wish to support a prosecution or have her son arrested. Instead, he was to stay with his father

temporarily. Police officers completed a SCARF referral. However, when completing the DASH risk assessment, the victim no longer reported being frightened of her son and the assessment was graded as standard risk. It was noted that the perpetrator was 'appalled' that he was not being financially supported by his mother.

4.25. The perpetrator then went to live in his father's pool house adjacent to his father's home. During this time, he held a job in a local shop and although drinking less than before, he was still drinking heavily, and smoking cannabis.

4.26. By the end of the year, he appeared more stable, and his stepmother provided him with the deposit for a flat share. However, his mental health soon deteriorated, he stopped talking to his father and stepmother, and his flat sharers wanted him to leave. He went to stay with his sister, who was at University in London, which was difficult because they were in cramped student accommodation and because he was depressed and financially dependent upon her.

Addictions Treatment

4.27. In March 2017, the perpetrator was admitted to the Priory Hospital North London as an informal patient, to undertake their Addictions Treatment Programme. His treatment was funded by one of his grandparents.

4.28. During his stay, he spoke angrily about his relationship with his parents. However, his reasons for having been asked to leave each of their homes were contradicted by a letter that his mother sent into the hospital explaining what had happened. He was not confronted by the detail of this letter which was not shared with her son. The letter has not since been made available to this review as it could not be located by the Priory Hospital.

4.29. The perpetrator was discharged from the Alcohol Treatment Programme after two weeks due to his failure to keep to group rules and boundaries. Whilst he agreed to stay and join the general group therapy programme, his engagement fluctuated, and he was discharged. He was considered to lack motivation to engage in therapeutic programmes. The plan was for his grandparents to arrange his accommodation and for the perpetrator to attend the day care programme, but the grandparents' funding for this was withdrawn shortly afterwards. The perpetrator did not consent to information being shared with his GP and so, in the absence of any medical

need or safeguarding concern, no discharge summary was sent. Three risk assessments were completed during his stay and each time indicated no risk to himself or others.

Shoplifting

4.30. After leaving The Priory in April 2017, the perpetrator reported having abstained from drugs and alcohol for a period of three months. He obtained work and rented a room in a young person's traveller hostel in East London. However, he began to gamble and relapsed into substance misuse and shoplifting.

4.31. Around this time, various members of the family discovered that the perpetrator had been asking for and receiving money from a number of them at the same time. They also discovered he was spending money on alcohol and drugs. They each stopped providing him financial support in the hope that he would accept some responsibility for himself.

4.32. During July and August 2017, the Metropolitan Police responded to five reports of the perpetrator shoplifting in London. The perpetrator told the police that he was of no fixed abode. He was cautioned (a warning) on the first occasion and charged on the fourth and fifth occasion. He later failed later to attend court for either offence and a warrant was issued for his arrest.

4.33. During these months, he was in custody three times and whilst in custody each time, he disclosed alcohol abuse. After the first occasion, he also disclosed previous self-harm and admitted to feeling 'a bit down' and so he was observed every 30 minutes whilst detained. He was noted to be of no fixed abode.

First burglary

4.34. At the end of August 2017, the victim contacted the police in the middle of the night as she believed that there was a burglar in her house. Her son had broken into her home after not being in contact with her for 16 months. He stole her laptop and car. The car was traced through Automatic Number Plate Recognition and the perpetrator was arrested by the Metropolitan Police as he approached London. He was then transferred to Sussex Police. A SCARF referral and DASH was completed and assessed as standard risk. The victim again responded that she was not frightened of her son.

4.35. Whilst in custody, the perpetrator showed no remorse and said, “It was my mum, she deserves it”. On this occasion, the victim supported the prosecution. The perpetrator pleaded guilty to burglary and aggravated vehicle taking for which he was fined and sentenced to a twelve-month community order which included a six-month drug rehabilitation requirement. The National Probation Service transferred the case to Kent Surrey and Sussex Community Rehabilitation Company (KSS-CRC).

4.36. He failed to attend his induction appointment and was issued with a final warning letter requiring him to attend an appointment in ten days’ time. The letter was left for him at Hastings Probation Office as he was of no fixed abode. After he had failed to attend his second appointment, breach action was initiated that day to take his community order back to court for non-compliance.

Second burglary

4.37. Within a week of his court appearance, the victim’s neighbours reported the perpetrator apparently trying to break into his mother’s house again. However, when the police arrived, the perpetrator was there with his mother and her boyfriend and there was no sign of damage or a break-in. Routine checks on the Police National Computer, found an outstanding warrant for the perpetrator who had failed to attend court regarding two offences of shoplifting. He was arrested and taken to the Metropolitan Police in whose area he was alleged to have committed the crimes. He was assessed by the Police and Court Liaison and Diversion Service (PCLDS) following a referral due to his disclosure of mental health needs and possible alcohol dependency.

4.38. The perpetrator discussed his current circumstances and the events of the past few months, including how he had become homeless, his substance misuse and his gambling. However, he only superficially engaged in the assessment process. No symptoms of acute mental illness were observed or described, and he did not appear to be in acute distress. He denied any thoughts of self-harm or suicide. No onward referrals to mental health services were deemed necessary at this time but he was encouraged to access relevant support services. He was given service information and contact details for Shelter, Crisis, Centre Point and Aspire which is a substance misuse service also offering support around homelessness and

unemployment. At Court he was sentenced to an eight-month conditional discharge.

4.39. A week later, whilst the victim was on holiday abroad, the perpetrator broke into her house again and stole jewellery worth approximately £20,000. A large kitchen knife was discovered on the toilet cistern upstairs, but police were unable to establish whether it belonged to the house or whether the perpetrator had brought it to gain entry. It was also believed that he had been staying in the house whilst his mother was away, without her permission. When the victim returned to the UK a few days later, a DASH was completed with her and assessed as standard risk again. On this occasion, when asked whether she was frightened of her son, she said, "not anymore. I am now more angry with him."

4.40. The perpetrator was arrested by the Metropolitan Police Service for breach of the community order, and for burglary of his mother's home. He appeared at Brighton Magistrates Court in early November 2017.

4.41. His previous community order was revoked, and he was re-sentenced to a further 12-month community order with the requirement of a 6-month drug rehabilitation requirement and a 20-day rehabilitation activity requirement (known as RAR) as he had done before.

4.42. During November 2017, there was some confusion over communicating the perpetrator's requirements to report to probation services. He did not appear to have been given a date to attend for his initial appointment with probation whilst he was at court, despite being of no fixed abode and having no phone. Nevertheless, he attended the local offices of Kent, Surrey and Sussex CRC the next day, only to be turned away as his case records had not been sent to them by the National Probation Service, and no further checks were undertaken by the CRC to clarify the position. Thereafter, he failed to attend further appointments and was uncontactable. The CRC undertook breach proceedings and a warrant was issued for his arrest.

4.43. In mid-November the perpetrator was found rough sleeping at Heathrow Airport by the Metropolitan Police. They completed background checks and it was ascertained that the perpetrator was not wanted or missing, and that no bail conditions prohibited him from being at the airport. Officers gave him advice on where to get assistance with accommodation.

4.44. At the end of November 2017, the perpetrator attended University College London Hospital Emergency Department, having taken an overdose of aspirin whilst heavily intoxicated and feeling stressed. He denied clear

suicidal intent. He was seen by the Mental Health Liaison Team's speciality doctor and told them that he had not been mistreated in childhood but had been very bored. He was not considered to have an acute mental illness, and that his risk to himself could be modified by addressing his substance use, which he was reluctant to do, and by addressing his lack of accommodation. Advice was given to him on registering with a GP.

4.45. The perpetrator was seen by the hospital's own Homeless Team before he left the hospital. They contacted a local young person's homeless service and arranged for him to attend there. The Homeless Team gave him some food and an Oyster card. They also offered to pay the travel costs for him to go to Sussex to see his family, which he declined. There is no record of him attending the young person's homeless service thereafter.

4.46. In early December 2017, the perpetrator failed to appear at Lewes Crown Court and a warrant was issued for his arrest. Within five days, he was arrested by British Transport Police at Waterloo Station for being in possession of a stranger's credit card whilst attempting to shoplift. Checks revealed that he was already wanted on warrant. Whilst in custody the perpetrator stated he had attempted an overdose the previous week but denied he wanted to take his own life. He was placed under 30-minute observations.

4.47. In January 2018, the perpetrator appeared at Hove Crown Court for sentencing for his second burglary of his mother's home. The Court requested a pre-sentence, oral, 'on the day' report, rather than a full report from the National Probation Service in order to determine the most appropriate sentence. The report referred to the perpetrator's wish to 'punish' his mother; the emotional and financial impact on her; the breach of trust involved and the fact that she had been victimised twice in a month. No significant mental health concerns were detected, although his depression was thought to possibly be exacerbated by drugs. The probation officer assessed him to be a confused, immature and detached young man with a limited appreciation of the impact of his behaviours on himself and others.

4.48. The perpetrator was sentenced to 16-months imprisonment, suspended for 2 years; required to serve 140 hours community service and issued a Drug Rehabilitation Order. He was also made subject to a twelve-month Restraining Order under the Protection from Harassment Act 1997, prohibiting from contacting his mother, directly or indirectly or from going to the road in which she lived.

Supervision by Probation Services

4.49. Although the perpetrator was by this time living in London, the National Probation Service, who are responsible for allocating cases after sentencing, changed their allocation from London CRC to Kent Surrey and Sussex CRC, which covers the area where he attended court and had been living previously. Moreover, due to an administrative oversight, Kent Surrey and Sussex CRC did not terminate his previous community order. The case was therefore treated as a transfer of a community order and suspended sentence order from Kent Surrey and Sussex CRC to London CRC and the two CRCs liaised over for the next two months over who should have ownership of the case. This created unnecessary delays in him being referred to substance misuse services.

4.50. Nonetheless, the perpetrator attended the London CRC as originally instructed after sentencing and continued to attend appointments through January and February 2018. He advised that he was residing in a hostel in London at this time and undertook a full induction with the offender manager in which he described his formative experiences and how he despised his upbringing and felt his mother was controlling. He went on to describe his motivation for his offending as the only way he could gain her attention as he was unable to communicate with her in any other way. He went on to meet with his offender manager and discuss his attempts to gain employment and wait for a referral to substance misuse services, despite a relapse in his drug use.

4.51. In early February, and despite having sufficient information, Kent Surrey and Sussex CRC only completed a basic assessment to facilitate his case being transferred to London CRC and in which they assessed his risk as low. London CRC requested that a full assessment be completed, given the risks that they had identified in this case. However, the full assessment, when completed, was not robust and perpetuated, incorrectly, his assessment as low risk of serious harm. It was considered that the information available at the time should have led to an assessment of medium risk which would have required an accompanying risk management plan being developed and monitored.

4.52. By mid-February, the perpetrator began missing appointments for undertaking his required un-paid work and latterly to meet with the offender manager, who did not send warning letters for the breach of his

sentence as required. Instead, attempts were made to contact him by phone at the hostel in East London and messages were left for him there.

Further Contact with Family

4.53. In April 2018, Surrey Police received a call from the perpetrator's stepmother reporting that the perpetrator was trying to force his way into her home. He was being verbally threatening, screaming abuse, circling the property, and hammering on the window, and she said that she was very scared. When the police arrived, they were told by his father and stepmother that the perpetrator had been demanding money after they had stopped paying for his hostel. Officers had been provided with a brief history of the perpetrator's mental health issues and substance misuse and noted that he was mildly intoxicated. However, he was calm and rational and did not display any concerns of disorderly behaviour in the presence of the police. Neither the perpetrator's father nor stepmother wanted any action taken against him but wanted him to leave them in peace. Police officers therefore took him to the local railway station so that he could return to London. They completed a SCARF including both Vulnerable Adult at Risk and DASH question sets, evaluated the risk as standard and forwarded details to Adult Social Care.

4.54. On the Friday in late April 2018, the perpetrator arrived unexpectedly at his grandmother's home in Kent and she contacted her daughter, the victim. Although the perpetrator was bound by a restraining order not to have contact with his mother, the victim told her mother that she should not have to deal with him and agreed to collect him from his grandmother at the end of the weekend.

4.55. On the evening of bringing him home, the victim took her son to the Emergency Department at Tunbridge Wells Hospital saying that she did not know what else to do. She was concerned that he was significantly depressed, not functioning and would "end up dead". By contrast, he initially denied depression, anxiety, thoughts of self-harm or any need for treatment, although it was noted that he felt "there was nothing good in his life since his drugs were taken" and his behaviour was considered to be bizarre. The Emergency Department further noted that he was homeless and was subject to a restraining order preventing him from contacting his mother.

4.56. He was referred to the psychiatric liaison and a mental health assessment was undertaken by Kent and Medway Partnership Trust, during which he disclosed that his mood was very low and that he had been self-medicating with recreational drugs. Although he recognised that these drugs made him feel paranoid and emotionally unstable, he felt that he needed them to survive. He particularly spoke about being paranoid about all cameras in London. The practitioner felt that he was under-reporting his substance use and noted that his mother also questioned his account.

4.57. The assessment took into account a full history including his two intentional overdoses; his suspended sentence and the restraining order that was in place. He was described as a little guarded about how he funded his drug and alcohol consumption but advised that he received universal credit, which had been topped up by his stepmother to pay for his hostel.

4.58. It was concluded that the perpetrator's symptoms were associated with substance misuse rather than any acute mental illness. It was considered that he would benefit from drug and alcohol services to address his self-medicating behaviours and, once this was under control, further discussions about treatment could be considered with the G.P. Kent and Medway Partnership Trust sent a letter to the GP that they believed him to be registered with, including the results of his assessment.

4.59. The victim advised that she was willing to have her son come home with her despite having a restraining order against him. Mental health practitioners considered the victim's role as a carer and noted that she shared no concerns with them beyond expressing that she wanted him to get help. However, the victim texted her daughter to say that the perpetrator was being referred back to the GP who she felt had done nothing 2 ½ years prior. Family members believed that the victim had become disillusioned and felt that no agency wanted to take responsibility for her son.

4.60. The following day, the perpetrator saw his former GP as a temporary patient, and was signposted to Health in Mind, which is a primary care mental health service, provided by Sussex Partnership. At Health In Mind, the perpetrator was assessed as having moderate depression and mild anxiety. He denied being dependent upon drugs and alcohol; denied having any thoughts of harming others but disclosed that he had become annoyed or irritable over recent days. He did not specify any individual object of irritability or provide any narrative around this.

4.61. Sussex Partnership triaged his case two days later. In the meantime, the victim had gone shopping in Brighton with her son and bought him some

new clothes. She reported to other family members that they had been getting on much better.

4.62. When Sussex Partnership triaged his case, they did not know that he had attended Tunbridge Wells Hospital and been assessed earlier in the week. During their triage process, which involved looking through their records alongside the new referral information, his risk was determined to be low. However, it was noted that there was some potential complexity in his presentation, so his case was passed to a primary care mental health practitioner for an initial routine face-to-face assessment.

4.63. Administrators attempted to contact both the mobile and landline numbers given by the perpetrator, in order to offer a face-to-face assessment with a primary care mental health worker, but he did not answer the phone.

4.64. Later that day, the perpetrator was arrested for killing his mother. A Mental Health Act Assessment was undertaken whilst he was in custody the following day where it was found that he had no sign of enduring mental illness.

5. Overview

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

Criminal Justice Agencies

5.1 Sussex Police

5.1.1 Sussex Police were called upon to respond to six 999 calls in respect of the victim and her son and treated each one as an emergency.

5.1.2 Their first involvement in 2015, however, was referred to them by the neighbouring Kent Police and concerned the perpetrator going missing from hospital before he had been fully assessed and when he was thought to be psychotic and potentially suicidal.

5.1.3 When Sussex Police located him, he was walking home and no longer presented any issues or exhibited behaviour to them which gave rise for

concern. He stated that he did not want to return to hospital. He told officers that he felt fine after clearing his head and listening to music and denied feeling suicidal or likely to harm himself. Although officers were aware of the detailed history passed on to Kent Police by the hospital and had instructions from Kent Police to return him to hospital, they did not consider that there were sufficient grounds to take him against his will. It was documented that in making this assessment, they gave due consideration to their police powers to detain him, under Section 136 of the Mental Health Act 1983.

5.1.4 When returning him home, Sussex Police were unaware that his sister was only 17 years old at this time and not an adult as thought. Whilst it was not good practice to leave the perpetrator in the care of his younger sister or check the ages of those present, records suggest that the officers judged the home address and persons present as adults and suitable to safeguard his needs. This assessment took into account that his sister's boyfriend was also present; police units had been deployed straight away to inform his mother at hospital to return home and there was no indication that the perpetrator presented as a risk or threat to others at this time. Their response was therefore considered mostly proportionate and in accordance with police safeguarding policy and procedure and they went on to submit a SCARF referral and a Vulnerable Adult at Risk (VAAR) referral as required. However, checking the ages of young people present would be considered expected practice.

5.1.5 At other times, there were five occasions when Sussex Police had an opportunity to arrest the perpetrator. On two of these occasions, the family declined to pursue prosecution. On the remaining three occasions, the perpetrator was arrested, charged and remanded in custody.

5.1.6 Sussex Police reflected on how they had responded to risk and made referrals to other agencies during the rest of their involvement. A DASH was completed in respect of each relevant incident and the risk to the victim assessed as standard on each occasion. It was reflected that by the time of the burglary, the risk could have been considered to have increased to medium. The perpetrator had committed a night-time burglary when there would have been a high probability that the house was occupied, had shown a lack of remorse to his mother and, on both counts, had provided a significant breach of trust.

5.1.7 It was also not apparent that the officers were considering the significance of economic abuse involved in the offence and this issue will be considered alongside other agencies in the thematic section which follows.

5.1.8 Two SCARF DASH question sets were not referred to the local Independent Domestic Violence Advisor (IDVA) service. In 2016, the situation of criminal damage was considered a “very low-level situation of risk” and detailed safety advice had already been provided. In August 2017, the DASH was not sent to the Portal for referral to domestic abuse services because the specialist officer considered that there was “no vulnerability obvious”. The Force procedures allowed that element of discretion in making referrals in each of these situations of standard risk. However, had her risk been assessed more appropriately at the time, it would have been expected that she would have been referred to domestic abuse services.

5.1.9 At the time of writing, Sussex Police are undertaking a full review of the Force’s approach to domestic abuse, including risk and partnership working. As this review is already in motion and scheduled to be considered by the Community Safety Partnership, no further recommendation have been made on these learning points.

5.1.10 The perpetrator’s most serious offending spanned a very short period of time during which he was arrested three times and put before the court. Although it would not have changed their response in this particular case, Sussex Police should have placed a marker on the victim’s address to show that a restraining order had been issued by the court in January 2018. As a result, Sussex Police have made a recommendation to undertake an audit of the application of these markers within the Force.

5.1.11 In other respects, it was clear that Sussex Police were balancing support for both the victim and her son, whilst taking punitive action against the perpetrator when it was found to be necessary.

5.2 Metropolitan Police Service

5.2.1 The perpetrator came to police attention on 8 occasions, predominantly in relation to shoplifting and burglary. They were also tasked to enforce the warrants to arrest him when he failed to attend court.

5.2.2 Each time that he was in custody, the perpetrator disclosed alcohol misuse, referring to himself by August 2017 as an alcoholic. Moreover, after his first period in custody, he consistently referred to previous self-harm, feeling

'down' and as a result was subject to 30-minute observations. On his last period in custody in December 2017, he disclosed that he had attempted suicide the week before by overdose but denied wanting to take his own life.

5.2.3 There was no information recorded by the MPS in relation to any consideration which may have been given to making referrals to other agencies regarding substance misuse or mental health services. However, since this time, arrangements have been put in place for a Liaison and Diversion Service in all police custody suites. The purpose of the service has been to identify people who have mental health, substance misuse or other vulnerabilities when they first come in contact with the criminal justice system as suspects, defendants or offenders. The service supports individuals through the early stages of the criminal justice system pathway, refers them for appropriate health or social care or enables them to be diverted away from the criminal justice system into a more appropriate setting.

5.3 National Probation Service (Sussex)

5.3.1 The National Probation Service was responsible for undertaking pre-sentence reports and once sentenced, allocating his case to the appropriate Community Rehabilitation Company who would supervise him thereafter.

5.3.2 The service was required to provide the court with a pre-sentence report on the perpetrator in January 2018 and, because of the nature of his offences, the court ordered that this be a fast, 'on the day', oral report in order to facilitate the national priority of speedy justice.

5.3.3 These reports do not require the same level of assessment as a full report, but the officer was able to highlight key aspects of the perpetrator's breach of trust and his wish to punish his mother, as well as assess his immaturity and lack of insight into the consequences of his offending behaviour. In this way familial abuse was clearly identified. However, information on police callouts was not able to be checked within the timeframe allotted to them. It was understood that a full risk assessment would take place at his initial appointment with the Community Rehabilitation Company (CRC) within 15 working days of sentencing. Nonetheless, a national recommendation has been made for the Ministry of Justice to consider whether a standard should be set for pre-sentence reports to require that police reports should always be sought when the offending is linked to domestic abuse and family

members. This would have the effect of enabling probation services to be given time to undertake the task of retrieving police reports.

5.3.4 The Serious Further Offence report also required that probation staff who attend court should undertake unconscious bias training as the class of the offender was seen to have influenced the decisions taken. Domestic abuse training is already mandatory for continuous professional development and will become part of professional standards which come into force during 2020.

5.3.5 On one occasion, the perpetrator did not appear to have been given an appointment to attend for his initial post-sentencing assessment despite being recorded as of no fixed abode and without a phone. A recommendation has been made to remind court duty officers to give appointments to offenders before they leave the court, wherever possible, and that these appointments should be detailed within the breach report.

5.3.6 The matter of allocation of the case to the regional CRC will be considered as a multi-agency issue in the thematic section which follows.

5.4 Kent Surrey and Sussex Community Rehabilitation Company (CRC)

5.4.1 The perpetrator was under the supervision of this CRC in respect of two community orders between August 2017 and January 2018. During this time, he did not comply with either order. The CRC had difficulty in enforcing the orders and they had no means of communicating with him as he was not known by them to be engaging with any other agencies. Nonetheless, Kent, Surrey and Sussex CRC have recognised that they missed an opportunity to engage with him when he attended their Hastings Office after receiving his second order. At this time, his case had not been transferred to their CRC within the expected timeframe and he was therefore not seen, and no further enquiries were made about his attendance.

5.4.2 Kent, Surrey and Sussex CRC have recognised shortcomings in the risk assessment that they undertook. The pre-sentence report, which had been undertaken by the National Probation Service, provided sufficient detail of the perpetrator’s personal circumstances for a full, rather than basic, risk assessment to be completed. This added further delays into the transfer as London CRC did not agree with the low risk of harm that had been assessed and they required that a fuller assessment be done before the transfer would be accepted.

5.4.3 Moreover, the quality of the risk assessment itself required improvement as checks had not been undertaken with partner agencies and particularly lacked information from police checks. Neither did the probation officer, known as the responsible officer, recognise the perpetrator's offending behaviour against his mother to be domestic abuse. This combination of omissions, together with his residence in London and a restraining order being in place, resulted in the perpetrator's risk against his mother to be assessed as low. Despite these protective factors, the CRC considered that the repeated nature of his offending behaviour towards his mother, his emotional and economic abuse and his ongoing hostility should have warranted an assessment of medium risk.

5.4.4 This minimisation of risk meant that a multi-agency risk management plan was not required and police liaison and actions to monitor domestic abuse and the restraining order were not undertaken. Although no later incidents were reported in respect of the victim and there was no indication that the perpetrator had any ongoing contact with his mother, the opportunity for more robust risk management was not pursued.

5.4.5 In recent months, and in response to the Serious Further Offence report on this case, Kent, Surrey and Sussex CRC have made significant improvement in their services which address each of the shortcomings detailed above. Most significantly they have introduced local quality inspections as well as routine dip sampling of cases, reviewing all cases before 12 weeks and introducing reflective supervision. They were also able to demonstrate mandatory domestic abuse training and that their policies and procedures require supervision and senior oversight where domestic abuse, including familial abuse, is a known feature. Their recommendations have therefore gone on to address the transfer of cases which are considered alongside other probation services later in the document.

5.5 London Community Rehabilitation Company

5.5.1 London CRC had contact with the perpetrator over three months between January 2018 to March 2018 and within that time he was seen seven times.

5.5.2 There was clear confusion at the start of the order regarding allocation and transfer of the case. As London CRC were not aware that the drug rehabilitation requirement from the previous order had been revoked, they continued to chase a referral to the provider from Kent, Surrey and Sussex

CRC. Despite this, the Offender Manager could have made a routine referral to the substance misuse service straight away.

5.5.3 Although significant information about his mental health and substance misuse was not available to any of the probation services, London CRC did not agree with the assessment of low risk undertaken by Kent, Surrey and Sussex CRC. They considered that the evidence of a restraining order and a second burglary against his mother would have indicated a medium level of risk. They then spent time liaising with them, rather than reviewing the assessment and devising a risk management plan themselves.

5.5.4 There was good evidence of the offender manager maintaining a positive working relationship with the perpetrator focussing on his offending behaviour and finding employment despite the absence of a risk management and sentence plan. However, there was a notable absence of discussion about his mental health.

5.5.5 Moreover, whilst the perpetrator complied with his reporting requirements consistently earlier in the order, he failed to attend both his unpaid work and his later appointments. In this way, his order was not enforced according to expected standards of practice. Official warning letters should have been sent and enforcement action taken if necessary.

5.5.6 When the perpetrator missed these later appointments, the offender manager took some good action to try to locate the perpetrator but did not contact the local police to explain that he was not in contact, or question whether any breach of the restraining order had been brought to their attention. It was not clear from the further attempts to engage him via letter, text and phone calls that any further appointments were offered. This is not consistent with practice standards that require a person on a community order to be issued clear reporting instructions. Failure to comply with those instructions should lead to enforcement action to swiftly return him to court or to re-establish his compliance.

5.5.7 Since the time of this case, London CRC has made significant changes which address many of these shortcomings including:

- Automated warning letters sent to service users where an appointment is recorded as an unacceptable absence, enabling timely enforcement action.
- All new cases received into London CRC are checked to ensure that any revoked orders/requirements are terminated and to check which orders/requirements are active and that future transfers are undertaken in a timely manner.

- A new management information tool has been introduced which provides staff and managers with information on cases that have not been seen.
- Quality assurance audits aligned to national guidance (HMPPS) are undertaken on a monthly and quarterly basis and providing feedback to front line practitioners about the management of their cases with areas of good practice and improvement.

5.5.8 Following the Serious Further Offence review, a remedial action plan was put in place and actions completed in line with the required Ministry of Justice framework. A mandatory 2-day interactive risk assessment training programme for all front-line practitioners has been implemented in addition to this.

Health Services

5.6 Primary Care

5.6.1 The victim attended her GP regularly during 2016 but less regularly thereafter. Her presentations mostly related to routine medical issues which were unrelated to domestic abuse, and no routine enquiry on domestic abuse was undertaken. Indeed, only one presentation may have been an indicator of domestic abuse. In March 2016 she complained of having strained her shoulder whilst trying to lift her son whilst he was drunk and said that she was “having trouble with him”. There was no record that these troubles were explored further or any record of her being given the opportunity to discuss the circumstances at home or be referred to domestic abuse services if necessary.

5.6.2 The perpetrator was registered at the same address as his mother until 2016. Between his return to the UK and March 2016, he was regularly seen in planned appointments and advice and encouragement to engage with substance misuse services was discussed at most of these. The perpetrator’s assessments with mental health services were all documented.

5.6.3 The GP noted that the victim was supportive of her son but there was no indication that her needs as a formal or informal carer for her son were considered or raised with her.

5.6.4 Sussex Clinical Commissioning Groups have therefore made recommendations for themselves to continue to promote the importance of routine enquiry regarding domestic abuse across primary care. It has also committed to strengthening awareness of the impact of supporting a family

member who has care and support needs and their need to respond, particularly regarding personal safety.

5.7 Sussex Partnership NHS Foundation Trust

5.7.1 The Trust provides specialist community and in-patient mental health services throughout Sussex. Their involvement in this case has been subject to a Higher Learning Review within the NHS Serious Incident Framework.[4]

5.7.2 The Trust's first contact with the perpetrator was in November 2015 and, in view of his behaviour and lack of insight into his mental state, the community psychiatric nurse (CPN) arranged a further assessment to identify if he had any underlying psychosis. The CPN went on to meet and assess him six times in total, enabling a thorough assessment, and involved the wider team and consultant, which was good practice.

5.7.3 During this time, he was seen to be maintaining a gradual recovery from his initial crisis and that alcohol and substance use had played a part in the deterioration of his mental state. The CPN was in regular contact with his stepmother, with whom he was living, and encouraged the perpetrator to engage with substance misuse treatment services. He was discharged after four months back to the care of his GP as he was not judged to have severe and enduring mental health problems. His primary issue was seen to be anxiety and the use of alcohol and substances to manage this, but despite considerable encouragement, he denied that he had a problem.

5.7.4 Due to the physical geography of where they lived, the boundaries of which Trust should provide care can be blurred. This was particularly the case when the perpetrator moved in temporarily with his father and stepmother. However, rather than delay services, Sussex Partnership notified all possible crisis and home treatment teams of a pending assessment and safety planned with his stepmother to attend the Emergency Department if the situation deteriorated. Although a carer's assessment was not offered to the perpetrator's stepmother who was more proactively involved at the time, it was clear that the CPN actively engaged with her whilst the assessment was ongoing.

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[4] Details of this framework are available at https://improvement.nhs.uk/documents/920/serious-incidnt-framwrk.pdf

5.7.5 At the time of the assessment, the risk to his mother was not known, although it was recognised that the relationship was strained and aggravated by excessive alcohol misuse. Consent had been obtained to speak with the victim and she attended an appointment with the consultant to discuss her concerns.

5.7.6 The Trust next saw the perpetrator when he disclosed mental health needs and possible alcohol dependence whilst in custody in September 2017. He was seen by the Trust's Police and Court Liaison and Diversion Service who were unable to conduct a full assessment of his mental state due to his superficial engagement in the assessment process. No symptoms of acute mental illness were observed, and he was provided with details of homeless and substance misuse services in London as he intended to return there.

5.7.7 The Trust's final involvement came in the final week of the victim's life, when the perpetrator referred himself to Health in Mind, which is the primary mental health service provided by the Trust under the NHS programme, Improving Access to Psychological Therapies. He was assessed, using nationally recognised tools (PHQ9/GAD 7),[5] as having moderate anxiety and depression, was self-medicating with drugs and alcohol, and displayed no thoughts of harming others. He was referred to secondary mental health services within the Trust.

5.7.8 Although Health in Mind use a different electronic case recording to the rest of the Trust and would not have been able to see his previous history, the referral was triaged using all his electronic case files as well as the referral information. He was still assessed as low risk but with some potential complexity of presentation, so was passed to their primary care mental health practitioner for an initial routine face-to-face assessment scheduled for 19 days later, within the nationally set assessment waiting time target of 28 days.

5.7.9 It was recognised that the Trust were not aware that the perpetrator had been assessed by a neighbouring mental health Trust within days of the referral, as there is no mechanism for sharing out-of-area assessments. However, it has since been able to establish that there was no clinical information in that assessment which would have altered Sussex Partnership's triage decision at this time as, similar to other decisions, the

[5] PHQ9 and GAD7 are evidence-based nationally recognised assessment tools used by all Improving Access to Psychological Therapies services.

primary concern was of substance misuse, and the risks to himself or others were identified as low.

5.8 Maidstone and Tunbridge Wells Partnership Trust

5.8.1 The Emergency Department of Tunbridge Wells Hospital saw the perpetrator with his mother on two occasions. On the first occasion in 2015 they promptly reported to the police when he left the Department before being fully assessed and alerted the police to the serious risk of self-harm that was known. As he had not been returned to the hospital, a doctor followed this up the next day by contacting the Police to check whether a vulnerable adult referral had been completed, which they agreed to do. This follow-up was good practice.

5.8.2 On the second occasion, the Department referred him to the on-call psychiatric liaison but nonetheless reflected that they had been aware that the perpetrator was subject to a restraining order not to contact the victim. Although the victim went on to tell the psychiatric liaison herself that the restraining order prevented her son from staying with her, the perpetrator was breaching the order by attending hospital with his mother. The Hospital considered that it would have been prudent to alert psychiatric liaison to the risk themselves and alert the police as necessary. They have made a recommendation for themselves to strengthen their domestic abuse policy and procedure in this regard.

5.9 Kent and Medway Partnership NHS Trust

5.9.1 The two referrals to psychiatric liaison from Tunbridge Wells Hospital went to Kent and Medway Partnership Trust. On the second occasion, the Trust also considered that they should have explored the issue of the restraining order fully within the assessment in order to ensure robust safety planning for both the perpetrator and his mother. Although the perpetrator denied any intent to harm others and the victim expressed no concerns for her safety, it was recognised that it would have been good practice to talk with the victim on her own; to ensure that she felt safe to have her son at home and to discuss the support that could be offered by domestic abuse services. The Trust considered that professional curiosity was lacking in this regard and made a recommendation for staff to ensure that they have explored the

reasons and context behind any protective tags or orders and report to the police where orders are being breached.

5.9.2 Since this time, the Trust has introduced domestic abuse awareness raising and training on safe routine enquiry for all staff at induction. This is reinforced and explored further through mandatory safeguarding training packages and bespoke domestic abuse training thereafter. The Trust has nonetheless made recommendations to increase confidence amongst all frontline clinical staff regarding routine enquiry about domestic abuse.

5.9.3 Beyond matters of risk management and safeguarding practice, it was evident that practitioners had taken a full social and clinical history and concluded that the perpetrator had no acute mental illness that required secondary mental health care, but that his symptoms were consistent with drug and alcohol misuse. The assessment concluded that he would benefit from drug and alcohol services to address his use and self-medicating behaviours and once these were under control, discussion about further treatment could be held with the GP.

5.10 Priory Hospital

5.10.1 The perpetrator attended the Priory Hospital North London as an informal in-patient for 17 days and attended an addictions treatment programme, then group programme, before discharge.

5.10.2 The Hospital reflected on the perpetrator's admission and discharge from hospital. It was considered that there was insufficient patient history gained at the point of admission, where it was recorded that he was living in a hostel having been required to leave both of his parents' homes. No detail of the context for these events was recorded and it was recognised that this context would have informed later risk assessments.

5.10.3 Likewise, steps have since been taken to improve the discharge plans for patients. Although there were no indication of safeguarding concerns or mental health needs that would have required the perpetrator to be referred to statutory agencies, it was considered that aspects of discharge planning needed strengthening. The Priory have therefore made recommendations to strengthen their assessment, transfer and discharge policies and procedures, particularly concerning the need for a safe discharge plan; the involvement of family and carers, where consent has

been given; in circumstances where funding has been stopped, clearly documented evidence needs to show whether an NHS referral is needed.

6 Thematic Analysis, Learning and Recommendations

6.0.1 In this section, the report considers the overarching themes arising within the review in respect of domestic abuse, substance misuse, mental health and offender management.

6.1 Indicators of domestic and economic abuse

6.1.1 A key function of domestic homicide reviews is to contribute to a better understanding of domestic abuse (Section 7, Multi-Agency Statutory Guidance, 2016). As the review progressed, a number of different facets of domestic abuse became apparent, although it is not known whether the victim herself would have defined her experiences in this way.

6.1.2 During the earlier reports, the victim disclosed to the police that she was frightened of her son and uncertain of what he might do in his mental state. Her disclosures of being frightened appeared to have diminished as his offending behaviour escalated and she told the police that she was then more angry than frightened. We do not know, however, whether her fear actually diminished at times, or as a whole.

6.1.3 In the meantime, the perpetrator was economically abusing his mother: he was financially dependent upon her; demanded money; became aggressive when money was refused; damaged her property; broke into her home at night and when she was away and stole a large amount of personal jewellery. Whilst the perpetrator was also manipulating other family members for money, and much of his behaviour appeared to be fuelling his alcohol and drug use, it was only his mother’s home that he was breaking into and only her property that he was damaging. In this way, many of his actions appeared, at least at times, to go beyond acquisitive, opportunistic crimes, and be targeted towards his mother directly. He was also seen to be using his position as a son to manipulate and coerce his mother to provide him with money.

6.1.4 Indeed, in many of his assessments with professionals, he spoke about his hostility to his mother and, on one occasion, disclosed to the police how he

was appalled that she was no longer supporting him financially. His sense of entitlement to be financially supported was made evident in his assessments with a number of agencies. In one particularly probing assessment with probation services, he described how he targeted his mother as the only means to gain her attention as he was unable to communicate with her in any other way. However, his explanation should not obscure the acquisitive nature of his crimes and his need to support to his gambling and illegal drug use.

6.1.5 Although Sussex Police completed a DASH on each occasion, recognising the perpetrator's acquisitive crimes as domestic abuse, the significance of economic abuse appears to have been obscured for them and other agencies. Agencies reported that the relative affluence of the victim, together with the relationship of mother and son, obscured their sight of the potential for economic abuse. Nonetheless, the perpetrator had aggressively demanded money and targeted his mother in his thefts and financial dependency.

6.1.6 Nonetheless, research has shown that economic abuse, "…rarely takes place in isolation. Challenge is dangerous, compelling a victim to act in accordance with the abuser's wishes rather than their own" (Sharp-Jeffs and Learmouth, 2017:4). Akin to other forms of domestic abuse, it is motivated by a sense of ownership and entitlement and this sense of entitlement was a constant feature in the perpetrator's presentations. Economic abuse needs to be seen as an indicator of coercive control and a recommendation is therefore made to promote awareness of the indicators of economic abuse and its significance to understanding risk. Enacting this recommendation to address the issues that we have seen in this case, will require an understanding of the particular challenges to identifying economic abuse within families and recognising that it can happen irrespective of the class and relative affluence of the family concerned.

6.1.7 At the time of writing, the Government has pledged to introduce new domestic abuse legislation (Queen's Speech, December 2019). The Domestic Abuse Bill 2020, which has had cross-party support, plans to introduce the wider definition of economic abuse, as a pose to financial abuse, and this recommendation could be seen to prepare agencies for incoming statutory duties.

Learning Point

Practitioners need to be curious and open to the possibility of economic abuse, particularly because it rarely happens in isolation. If we miss economic abuse, we may potentially be missing the opportunity to uncover other possible forms of coercive control and domestic abuse.

Recommendation
East Sussex Safer Communities Partnership should promote public and professional awareness of economic abuse as a method of coercive control within domestic and familial abuse. They should seek assurance from its agencies that they have enacted the new definition of economic abuse within their policies and practice.

6.2 Adult Child-to-Parent Abuse

6.2.1 It is noted that despite significant policy attention being drawn towards domestic abuse in recent years, abused parents' experiences have received comparatively little attention compared to those experiencing inter-personal abuse (Bows, 2018). Abuse that is committed by sons and daughters when they are adults, appears even less researched.

6.2.2 National guidance on child-(adolescent)-to-parent abuse has emphasised that isolation, stigma, shame, guilt and fear are particular barriers for parents in seeking help and that these barriers are compounded by the fear of blame and responsibility for the shortcomings in their own parenting (Home Office, 2015b:5). Indeed, research with abused parents found that many parents felt guilty; felt that they had failed in the parenting role; felt that the behaviour of their children was at least partly their fault and found these feelings were exacerbated when their child also misused drugs or alcohol (Adfam, 2012).

6.2.3 The Home Office goes on to describe behaviour which appears, at least in part, applicable to his case:

> *"… children had smashed up property, kicked holes in doors, broken windows, had thrown things at their parents and made threats. Verbal abuse and other controlling behaviours were also commonly present. This pattern of behaviour creates an environment where a parent lives in fear of their child and often curtails their own behaviour in order to avoid conflict, contain or minimise violence." (Home Office, 2015)*

6.2.4 Although there are many similarities with interpersonal domestic abuse, there are distinct qualities of child-to-parent abuse, not least that it becomes an inversion of the usual parent to child power relationship and it is expected that parents will be able to assert power and control over their children (Condry and Miles, 2014:3). It is further recognised that parents face particular difficulties in reporting or taking action against their own child (Condry and Miles, 2014:15). In the earlier reports, the victim, like others, was reluctant to take action against her son and although she consented to criminal action being taken when the perpetrator's behaviour towards her worsened, it was clear from her dealings with agencies throughout these years that she nevertheless wanted her son to receive help.

6.2.5 In this light, the panel considered the victim's motivations when she allowed her son to stay with her in the final days of her life. We have seen that her son approached his maternal grandmother unexpectedly and the victim picked him up and took him home. She had told her mother that "she… [his grandmother] … should not have to deal with him." The panel considered a number of possible motivations including wanting to protect her mother from her son's abusive behaviour, feeling responsible for her son, or not feeling able to do otherwise. Whilst each of these possible motivations was understandable, it is acknowledged that her actual motivation cannot be known.

6.2.6 Research has shown that many abused parents question the intent of their child: questioning whether the intention is to cause harm and control the family or whether the behaviour is an extension of their child's mental health or substance misuse, with the corresponding assumption that if treatment were found, the abusive behaviours would stop (Adfam, 2012). As a result, research found that few parents considered that they were experiencing domestic abuse and therefore few had considered approaching a domestic abuse service (ibid).

6.2.7 Family members noted that the perpetrator consistently blamed other people for anything that went wrong. He blamed his parents for splitting up, and for not telling him that he had social anxiety. However, they considered most of all, that he blamed his mother and, in doing so, his perceptions of her became a trigger for his own anxiety.

6.2.8 Although the victim approached various agencies for help with her son, including the police, GP, hospital and mental health services, it was not

known whether she was aware of domestic abuse services or their role in child-to-parent abuse. Indeed, the review was unable to establish whether the victim defined her experience as domestic abuse, but there were several missed opportunities to refer the victim to specialist services. For example, on the first occasion in 2016, the GP did not explore further with the victim her disclosure about 'having trouble' with her son over his problematic alcohol use. Had this led to routine enquiry over domestic abuse, it may have prompted discussion about the support that could be offered by domestic abuse services. Likewise, on neither occasion when a DASH was completed by the police did they refer the victim to domestic abuse services, latterly saying because they felt that there was no 'obvious vulnerability' for the victim in relation to her son's mental health. Further example of missed opportunities to refer to specialist domestic abuse services occurred when the hospital Emergency Department became aware of the restraining order being in place and when the victim met alone with her son's mental health consultant. Specialist domestic abuse services, had she engaged with them, would have helped her define her experiences, provided support and help consider her safety from this perspective.

6.2.9 The local area has recently been re-focussing its strategy and commissioning around domestic abuse to take greater account of vulnerability and safe, whole family approaches. During their consultation, practitioners told them they often did not know what to do when they encountered familial and child-parent abuse, and this supported the new focus, commissioning and training that will support it.

6.2.10 In terms of the responses of agencies in this case, it is not known whether more attention might have been given by the police to positive arrest at different times, had the case involved interpersonal domestic abuse as a pose to child-parent abuse. It is further questionable whether the Emergency Department and mental health services may have been more concerned about an abused woman returning home with an abusive partner than an abusive son. However, agencies need to be mindful about the risk of unconscious bias and assumptions being made which may minimise the specific risks inherent in child-to--parent abuse.

Learning point:

Practitioners need to be aware of the particular barriers that mothers face in defining their experiences of child-to-parent abuse as domestic abuse and they should always be signposted to specialist domestic abuse services

Recommendation:
East Sussex Community Safety Partnership should seek assurance from its agencies that front-line practitioners are sufficiently supported through training, guidance and supervision to be able to respond effectively to child-to-parent abuse, irrespective of the various ages of those abusing and abused.
Where gaps emerge, East Sussex Community Safety Partnership should consider what needs to be collectively done with agencies to raise the awareness and expertise of practitioners to respond to child-parent abuse.

Recommendation
East Sussex Safer Communities Partnership should increase public awareness about child-parent abuse and the role of specialist domestic abuse services in supporting those affected

6.3 Substance misuse, gambling, addictions and mental health

6.3.1 The victim clearly tried hard to get treatment for her son, but it was not always clear what treatment he needed or where best this could be provided, as the relationship between his mental health and substance use was subject to professional assessments. During the period considered by this review, her son variously suffered from moderate anxiety and depression; alcohol dependence; took reckless amounts of recreational drugs; overdosed on aspirin; self-harmed; considered suicide; gambled and was seen to be using alcohol and drugs to self-medicate.

6.3.2 After his first period of significant distress in 2015, he had a long and thorough mental health assessment and was found not to be experiencing acute or serious enduring mental illness. It was considered that his symptoms had been brought on by substance misuse. This assessment was consistent throughout the following years and he was repeatedly warned about the seriously detrimental effect that substance misuse would have on both his mood and his behaviour. For most of the time, the perpetrator denied that his substance misuse was problematic, despite it being evident to both his family and to professionals, and he was resistant to seeking treatment.

6.3.3 The relationship between mental health, substance misuse and domestic abuse is a complex one. Whilst some research indicates that a history of mental health increases the likelihood of perpetration of domestic abuse (Oram et al, 2013) there is much research still needed to understand this phenomenon better (Hester et al., 2015; Yapp et al, 2018).

6.3.4 There is no doubt that the perpetrator felt hostility to his mother and deliberately targeted abuse towards her. However, the degree to which his anxiety and lapses into episodes of worsening mental health, fuelled by substance misuse, exacerbated his thoughts and behaviour cannot be known with certainty. Indeed, the perpetrator was never actively engaged in treatment and so the impact of his substance misuse on his behaviour was not assessed from this perspective.

6.3.5 However, from a domestic abuse perspective, it is important to assess the perpetrator’s behaviour in terms of his manipulation and control of others. His mother was often alarmed by her son’s behaviour and took him to Emergency Departments at these times of crisis. By contrast, it was noted that he was frequently much more coherent when he was seen by health professionals. Likewise, on several occasions when the victim called the police because of her son’s volatile, aggressive and erratic behaviour, he appeared calm and rational when the police arrived. It therefore appeared that he was able, at times, to control his own behaviour when it was in his interests to do so, irrespective of how at other times, his behaviour may have been exacerbated by substance misuse and anxiety.

6.3.6 Guidance produced by Alcohol Concern and the AVA Project (2016) concerning change-resistant drinkers recognised that problematic alcohol use, for example, and poor engagement with alcohol treatment featured regularly in domestic homicide reviews. The review therefore considered whether more could have been done to enable the perpetrator’s engagement with alcohol and substance misuse treatment. It was clear that mental health services consistently encouraged the perpetrator to seek treatment and it was considered that the only missed opportunities in this regard, were when he was in custody.

6.3.7 Dual diagnosis is a term applied to individuals who have acute and enduring mental illness and also misuse substances. Although the perpetrator displayed symptoms of anxiety, he was not diagnosed with an acute or enduring mental illness that would require secondary mental health care

treatment and so it was right that he was not considered for services for dual diagnosis.

6.4 Managing Offending Behaviour

6.4.1 Family members questioned how the perpetrator had been held accountable for his behaviour as they considered that he faced no consequences except when he failed to attend court hearings. The panel therefore considered carefully what opportunities there were to address and prevent his abusive behaviour and to check for any unconscious bias within agency responses.

6.4.2 Each of the perpetrator's criminal offences were acquisitive in nature. Sussex Police officers were observed to have struck a good balance between responding to the needs of both the victim and her son whilst taking punitive action against her son when necessary. They recognised that ultimately the perpetrator needed to engage with mental health services and/or a substance misuse treatment programme but still attempted to remove and reduce the threat posed by him by means of arrest, detention and seeking enforcement through the courts on each available occasion.

6.4.3 London CRC noted that it was unusual for an individual not to have received a custodial sentence for these offences and they observed that the court had wanted to give the perpetrator a final chance despite his repeated failure to attend. However, it is not within the scope of a domestic homicide review to comment on judicial sentencing.

6.4.4 Nonetheless, after the perpetrator was sentenced in December 2017, we have seen that there were significant delays in transferring the management of his case between the National Probation Service and the two Community Rehabilitation Companies. Although London CRC continued to meet with the perpetrator, the lack of a robust risk and sentencing plan during this time meant that there were no contingencies in place if he failed to engage. It also led to delays in his referral to substance misuse services under the community order and it was not until mid-February 2018, that the perpetrator was referred to a substance misuse service to access support, although he did not engage thereafter.

6.4.5 The process by which the delays occurred is complex and in part referred to within under the analysis for each probation service above. However, there is a need to examine their responses together. When the perpetrator was

sentenced in Lewes Crown Court, he told the court that he lived in London. The National Probation Service (Sussex) therefore allocated his case to London CRC but shortly afterwards changed their allocation to Kent, Surrey and Sussex CRC. The National Probation Service was not able to establish the rationale for the change and have recognised a need to ensure in the future that the reasoning behind any allocation changes needs to be recorded.

6.4.6 Kent, Surrey and Sussex CRC went on to make two administrative errors that delayed the allocation of his case to London CRC further: they failed to terminate the previous community order that the court had revoked and incorrectly accepted the case which should have been referred to London. As a result, Kent, Surrey and Sussex CRC have put in place administrative checklists to ensure that these omissions are not repeated elsewhere.

6.4.7 A ping-pong between the two community rehabilitation companies followed regarding who should be responsible for the referral. Kent, Surrey and Sussex CRC have recognised that their probation officer lacked robust oversight of the transfer. It was observed that there was a sense of diffused responsibility between the two community rehabilitation companies with neither accepting responsibility during this period and that better joint working, including discussion by telephone as well as by email, may have broken down barriers. Likewise, London CRC considered that their offender manager should have taken a more active role in undertaking a fuller risk assessment and referring the perpetrator to substance misuse services whether the drug rehabilitation requirement was current or not.

6.4.8 Aside from these factors, the perpetrator failed to attend for unpaid work and failed to attend appointments. Had these breaches been enforced appropriately, the perpetrator would have been in breach of his order, and the court may have activated the custodial element of the sentence.

6.4.9 It is worth noting that the government published in May 2019 the 'Strengthening Probation Building Confidence: Response to Consultation' Report and the subsequent 'The Proposed Future Model for Probation; A Draft Operating Model' (June 2019). These proposals outline the plans to unify case management within probation services once more. Transition work to oversee the implementation of the new model is underway to support the changes which will take place in 2021.

6.4.10 It is not known whether the unification of probation services could have helped resolve the transfer issues in this case. However, in the meantime, London, Kent, Surrey and Sussex and Essex CRCs are developing a transfer

protocol. They have made further recommendations to embed internal guidance on transfers and to emphasise their responsibility for ongoing cases during the period of transfer.

6.4.11 The final point in relation to agencies' ability to contain the perpetrator's behaviour, relates to the restraining order that was in place at the time of the manslaughter. Although the victim allowed her son to stay at her home when he breached his restraining order, we have seen that she may have felt that she had little choice but to do so. Up until that point, the restraining order appears to have dissuaded the perpetrator from approaching his mother's home. Having said that, it did not prevent him from approaching his maternal grandmother and it would have been predictable that his mother would have had to become involved when he did so.

6.4.12 From an agency perspective, the review has recognised the importance for all agencies in acting to reinforce measures taken against domestic abuse perpetrators so that the onus is not on the victim to protect herself. The two health agencies who were aware that the breach was going to happen, have embraced this recommendation. However, acting to reinforce measures needs to be undertaken with care and staff need to be supported with robust procedures and training to do this safely, accompanied by safety planning with the victim wherever possible.

Learning point:
It is the responsibility of all agencies to reinforce measures, such as restraining orders, that are taken against domestic abuse perpetrators and staff need to be supported to undertake this safely.

(National) Recommendation:
The Ministry of Justice is asked to consider whether a standard should be set for pre-sentence reports involving domestic abuse, including those pre-sentence reports which are required verbally and 'on the day', to routinely include evidence of police reports, necessitating the time being allocated for them to be carried out.

6.5 Managing Risk

6.5.1 A thematic analysis of domestic homicide reviews undertaken by Standing Together, identified key indicators of risk associated with familial domestic homicide including, amongst other factors, an abuser having: suicidal

thoughts; a sense of entitlement to financial resources, and issues with addiction (Sharp-Jeffs and Kelly, 2016).

6.5.2 Agencies had no means of anticipating that the perpetrator's violence and abuse would escalate as quickly as it did in this case. Police, probation services and health agencies each assessed his threat to others as low during their assessments. However, we have seen that both police and probation services could have assessed his threat as medium risk following the second burglary of his mother's home. For the police, this would have strengthened the impetus to refer the victim to domestic abuse services. For probation services, this would have required the implementation of a risk management plan and the case being flagged to supervisors. Recommendations around these issues have been addressed to the individual agencies concerned.

Learning point: Risk in Familial Abuse
This review provides further evidence of some of the key indicators of risk associated with familial domestic homicide including an abuser having suicidal thoughts, issues with addiction and a sense of entitlement to financial resources.

6.5.3 It was noted that Sussex Police had recently been one of the pilot areas for the new Domestic Abuse Risk Assessment (DARA). Evidence from the pilot suggested that the new assessment enabled a more accurate assessment of risk with a particular increase from standard to medium risk (Wire and Myhill, 2018: iii). Unlike other pilot areas, Sussex Police were able to show this improved accuracy of risk assessment in relation to familial abuse and these developments are therefore welcomed.

6.6 Good Practice

6.6.1 This review has focussed so far on the lessons to be learnt from the shortcomings of agency responses. It is important that acknowledgement and lessons are also learnt from the good practice that was observed during this period. Good practice included:

- The liaison between the hospital and police, and the police's mobilisation to find the perpetrator when he went missing from hospital in 2016 demonstrated a commitment to find a vulnerable young man at risk.

- Adult Social Care moved quickly to attempt to offer the victim a carer's assessment before her son's mental health had been fully assessed, demonstrating a commitment to early intervention.
- Despite many indications leading to the conclusion that the perpetrator's first significant episode had been a consequence of substance misuse, Sussex Partnership NHS Foundation Trust provided a robust assessment of his mental health over several months to ensure that there was no underlying mental ill-health.
- The integrated homeless service at University College London Hospital was able to provide a seamless service to the perpetrator when he was homeless and attending hospital in 2017.
- The GP made the perpetrator a temporary patient and saw him quickly when referred by acute mental health services in 2018 enabling him to access mental health services at a primary care level.

6.6.2 In demonstrating this good practice, it is possible to form a more rounded view of the services that agencies provided. It has also been possible to recognise that many agencies were trying to encourage the perpetrator to seek treatment for his substance misuse, yet he continued to deny that his use of alcohol and drugs caused him any problem.

7 Conclusions

7.1 This review has considered the nature of the domestic abuse that a son perpetrated upon his mother before killing her, and the nature of the agencies' responses over the two years before the victim's death.

7.2 Whilst the perpetrator repeated acquisitive crimes and manipulated his extended family in order to fund his use of illicit drugs and alcohol, he targeted his mother for burglary, theft and aggressive demands for money. The review demonstrated that domestic abuse is not class-specific and concluded that practitioners need greater awareness of economic abuse.

7.3 The extent of the domestic abuse and coercive control was not known, but when the victim attended health settings, there were missed opportunities for routine enquiry into domestic abuse.

7.4 The perpetrator was given a final chance by the court to address his offending behaviour and substance misuse, but he continued to fail to attend appointments with probation and breached his orders. Although he

recognised the detrimental impact of substance use on his mental health, the perpetrator was not motivated to address his problematic alcohol and drug use. However, agencies could have done more to encourage his engagement and probation services delayed in requiring his engagement with substance misuse services as the ownership of his case ping-ponged between two community rehabilitation companies.

7.5 In the final instance, the victim appeared to feel obliged to have her son return home despite a restraining order preventing his contact and she tried to seek help for his worsening mental state. The review identified that domestic abuse in the context of child-to-parent abuse is perhaps less understood than domestic abuse within intimate partner relationships and there are particular barriers that parents, and mothers in particular, face. Practitioners need to better understand child-to-parent abuse and ensure that their assessment of risk is not minimised by unconscious bias about the nature of the relationship.

7.6 Sadly, this report reflects how the victim was overshadowed in life by her son's dominant demands and sense of entitlement. Likewise, the review panel recognised that the voice of the victim has been overshadowed in this report by the analysis of service responses to her son and, in the final instance, her voice was not heard sufficiently in this regard either.

8. Recommendations

8.1 Overview Recommendations

Recommendation 1: Coercive Control
East Sussex Safer Communities Partnership should promote public and professional awareness of economic abuse as a method of coercive control within domestic and familial abuse. They should seek assurance from its agencies that they have enacted the new definition of economic abuse within their policies and practice.

Recommendation 2: Child-to-Parent Abuse
East Sussex Community Safety Partnership should seek assurance from its agencies that front-line practitioners are sufficiently supported through training, guidance and supervision to be able to respond effectively to child-parent abuse, irrespective of the various ages of those abusing and abused.

Where gaps emerge, East Sussex Community Safety Partnership should consider what needs to be done collectively with agencies to raise the awareness and expertise of practitioners to respond to child-parent abuse.

Recommendation 3
East Sussex Safer Communities Partnership should increase public awareness about child-parent abuse and the role of specialist domestic abuse services in supporting those affected

Recommendation 4: Pre-Sentence Reports for Domestic Abuse Offences (National)
The Ministry of Justice is asked to consider whether a standard should be set for pre-sentence reports involving domestic abuse, including those pre-sentence reports which are required verbally and 'on the day', to routinely include evidence of police reports, necessitating the time being allocated for them to be carried out.

8.2 Individual Agency Recommendations

8.2.1 Sussex Clinical Commissioning Groups

The CCG to continue to promote the importance of routine enquiry regarding domestic abuse across primary care.

Health professionals to have awareness of the impact of supporting a family member who has care and support needs. Further training for all staff to be considered on what the impact is on the wider family / carer / support system. Consider placing a flag or note on the electronic patient record system as a reminder to approach how the carer is feeling and to ask if they have any concerns regarding their personal safety.

8.2.2 Kent and Medway Partnership Trust

Any disclosure of 'a protective' 'restraining' 'police' or other order including tags etc must be explored for the reason why this has been put in place, this includes making contact to the police to report a breach.

To increase confidence amongst KMPT staff regarding routine enquiry around domestic abuse.

8.2.3 Kent Surrey and Sussex Community Rehabilitation Company

KSS CRC to improve their practice around case transfers.

8.2.4 **Maidstone and Tunbridge Wells NHS Trust**

Identify actions in the updated version of the Domestic Abuse Policy and Procedure to inform staff what actions are required when a patient states they are going to be discharged to live with the perpetrator and there is a restraining order in relation to living or being near to the perpetrator, that staff should inform the police that this is likely/going to occur.

8.2.5 **National Probation Service Sussex**

A further reminder to Sussex CDO's that following breach hearings, if order continues, the CDO must make efforts to give a reporting appointment before the offender/ service user leaves court. CRC if asking for orders to continue, will also ensure appointments are detailed within the breach report where possible, or an appointment date advised once a breach hearing date is known either directly to NPS Court Team or to the CRC staff member attending Breach Court in support of the process. If an offender fails to attend a Breach hearing and subsequently attends on warrant, NPS Court staff must take all reasonable steps to secure an appointment date and time.

NPS to continue to apply national allocation process.

Court report writers to check call out information when the offending is linked to family members and or grievances involved. All court staff will over the following year will be undertaking unconscious bias training as provided by the Civil Service. As part of our continuous professional practice events, Court report writers will continue to apply reflective practice approaches to discuss potential risk issues around similar cases.

8.2.6 **Priory Group, Priory Hospital North London**

During the discharge process, clarity should be given to family, carers and professionals in respect of risk. A telephone contact with the patient will be made within 48 hours of discharge and a discharge letter will be sent to all those involved with the patient's care with 7 days.

On admission, each patient should receive a comprehensive joint risk assessment by nursing and medical colleagues which needs to be documented on their care records. This will include an assessment of risk and establishment of observation level.

8.2.7 **Sussex Police**

That Sussex Police conduct an audit to ensure that history markers are being applied consistently and appropriately in cases involving allegations of Domestic Abuse.

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APPENDIX 1: ACTION PLAN

DHR Adult K Multi Agency Action Plan

Ref	Recommendations	Action	Key milestones and Progress	Target Date	Lead	Desired Outcome of the Action	Monitoring arrangements and evidence	RAG rating
OVERVIEW RECOMMENDATION 1: Coercive Control								
1.	**The East Sussex Safer Communities Partnership should promote public and professional awareness of economic abuse as a method of coercive control within domestic and familial abuse. They should seek assurance from its agencies that they have enacted the new definition of economic abuse within their policies and practice.**	A recommendation is made to the East Sussex CSP Board to request that each agency represented at the Board asks their agency to review their DVA policy and ensure they have enacted the new definition of economic abuse within their policies and practice	Recommendation made to the Board on 26th November 2020 to circulate a briefing provided on economic abuse and coercive control. The new definition of economic abuse and expansion of the offence of coercive control, following the introduction of the DA Act, will be included in a Briefing submitted to the Board A recommendation will be made to request assurance from agency reps that they have enacted the new definition within their policies and practices	Jan 2021	Joint Unit for DVA/SVA/VAWG	Increase in levels of reporting economic abuse to Police and services, resulting in decisive action to stop people experiencing economic abuse	Review of referral figures and source of referral, including self-referrals re economic abuse from agencies and within Annual Police Crime Survey to evidence whether or not there has been an increase in reporting of economic abuse	

		CSP agencies to keep the Board updated on when policies and practice will be updated with the new definition of economic abuse and notify the Board when this action is complete.	Assurance provided Policies and practice updated where gaps are identified Recommendation to be made to the Board to request any agencies that have not yet included the new definition of economic abuse within their policies and practices to advise the Board of this with a timeframe for completion and to notify the Board once completed.	Jan 2021	East Sussex Safer Communities Board members	Increase in the number of referrals and safety plans produced for victims of economic abuse, resulting in the improved safety of victims of economic abuse	Review of referral figures, including self-referrals, to monitor increases in referrals reporting economic abuse by agencies, including specialist domestic abuse service and MARAC Review of number of safety plans for victims of economic abuse as per contract monitoring arrangements of the commissioned specialist domestic abuse service	
		That agency representatives on the East Sussex CSP Board circulate the new definition of economic abuse and information on economic abuse within their agencies and wider networks	Agency representatives on the CSP Board circulate definition and information within their agency and wider.	Dec 2021	East Sussex Safer Communities Board members			

		For agencies represented on the CSP Board to include the definition and information on economic abuse on their public facing online platforms, where appropriate.	Recommendation to the CSP Board to include the definition and information on economic abuse on their online platforms and social media Agencies sharing definition and information on public facing online platforms	Jan 2021	East Sussex Safer Communities' Board members	An increased understanding amongst the public of coercive control and economic abuse, generating more confidence to report instances of this type of abuse, helping specialist providers, police and other partners to proactively disrupt abusers, hold them to account, and protect victims.		
		Information on economic abuse updated with promotion materials for the recommissioned DVA service in East Sussex	Content of promotion materials including information on economic abuse agreed between DVA service and Commissioner. Promotion materials in circulation	Dec 2021	Commissioned DVA service in East Sussex & Joint Unit for DVA/SVA/AWG	Increase in the number of contact, referrals and safety plans produced for victims of economic abuse, resulting in the		

			Commissioners have requested that the commissioned domestic abuse service include information on economic abuse within any promotional materials for the Service and on their public facing website.			improved safety of victims of economic abuse		
		Practitioners to complete holistic assessments, considering indicators of economic abuse and child-parent abuse alongside additional vulnerabilities such as a person's substance misuse, gambling dependencies and their mental health	Incorporated into practitioner assessment and safeguarding guidance.	Ongoing	CSP reps	Increase in victims of economic abuse and child-parent abuse being identified and safety plans in place	Audit and quality assurance mechanisms across agencies	
		Training on economic abuse for professionals will be provided	Multi-agency coercive control training has been rolled out across East Sussex	April 2021	Commissioned DVA service in East Sussex &	Professionals will be better equipped to	Review of agency training feedback forms/	

		by the commissioned DVA service for East Sussex.	in 2019-2020, with further roll outs in 2020-2021. This training covers economic abuse as a method of coercive control. DVA training by the DVA provider in East Sussex as a contractual requirement as is open to all CSP agencies. Agencies also provide the own training targeted to their area of work including ESCC ASC, the CCG and Children's Services The SAB Safeguarding Conference in East Sussex, held in February 2021, incorporated learning from statutory review processes, including DHRs, where coercive control has been a feature.		Joint Unit for DVA/SVA/AWG	identify and support victims of economic abuse and coercive control	surveys to include response about utilisation of training within practice and confidence levels with regards to understanding of economic abuse Managers to discuss implementation of training in practice within supervision with practitioners	

		Agencies to develop training feedback forms/ surveys circulated three months post training	On 15th June 2021 the Joint Unit hosted a DHR learning event which included learning from this DHR and information about economic abuse as a method of coercive control. The service specification for the recommission of DVA services in East Sussex includes the requirement for the provider to delivery multi-agency training, which will include economic abuse.	March 2022		As above	As above	
OVERVIEW RECOMMENDATIONS 2 & 3: Child-to-Parent Abuse								
2	**East Sussex Community Safety Partnership should seek assurance from its agencies that front-line practitioners are sufficiently supported through training, guidance and supervision to be able to respond**	Multi-agency training to be delivered that addresses child-parent abuse Operational Managers to identify any training needs for supervisors with regards to child-parent abuse	Multi-agency training planning Delivery of training The service specification for the recommission of services includes additional multi-agency training based on local priorities. This will include child-parent abuse as a	April 2021	Commissioned DVA service in East Sussex & Joint Unit for DVA/SVA/AWG	Practitioners are able to identify and provide effective support for those involved in inter-familial abuse, irrespective of age	Training survey 3 months after training delivery to review practitioner levels of confidence and implementing training in practice Tracking management attendance at training sessions	

	effectively to child-parent abuse, irrespective of the various ages of those abusing and abused. Where gaps emerge, East Sussex Community Safety Partnership should consider what needs to be done collectively with agencies to raise the awareness and expertise of practitioners to respond to child-parent abuse.	and signpost to training	recommendation of this DHR. This training will be open to practitioners of all levels, including supervisors and will highlight and encourage the need to discuss complexities of child-parent abuse.					
		Regular supervision continues to be provided to practitioners	In place and ongoing	Ongoing	CSP agency reps	Practitioners in operational teams are supported and given guidance through supervision of cases of domestic abuse so that practice is reflective and continually improving	Operational management to monitor via team meetings and monitor within line management of supervisors	
		Operational managers to ensure that practitioners are utilising professional consultation with CGL on domestic abuse issues,	Increase in practitioners utilising consultation with CGL for specialist support and advice	Ongoing	CSP agency reps	Improved response, support and safety planning for victims of domestic abuse, including	Monitoring of the number of practitioner consultations with CGL to track increases incorporated within KPI reporting of the	

		including child-parent abuse				child-parent abuse	domestic abuse service contract	
		Practitioners to refer clients to specialist services for support including CGL, as the specialist commissioned domestic abuse service Where there are low referral numbers from agencies, CGL to target promotion of the service and referral pathways with those agencies	There has been an upwards trend of practitioners from key agencies referring clients for support Home Start are commissioned in East Support to support victims of adult child-parent abuse until 31st March 2023	Ongoing	CSP agency reps	Clients are referred by agencies for support from CGL as the specialist domestic abuse service in cases to adult child to parent abuse, resulting in a more effective response to abuse of this nature	Number and source of referrals monitored and tracked as part of contract monitoring and incorporated into KPIs.	
		Monitor the number of referrals of child-parent abuse to the DVA and HIDVA service in East Sussex and track increases/ declines in referrals	Monitoring in place and shared as part of contract monitoring for the DVA service and HIDVA service in East Sussex	April 2021	Commissioned DVA service in East Sussex & Joint Unit for DVA/SVA/AWG	Improved identification and support for victims of domestic abuse, including child-parent abuse, that access hospitals in East Sussex	Monitoring of increases/ decreases in child-parent abuse by the DVA service in East Sussex as part of the contract monitoring of the Service	

						reducing the amount of time a victim is living with abuse		
		A recommendation to be made to the CSP Board to circulate resources on child-parent abuse around their agencies and wider networks.	Recommendation made to the CSP Board	Nov 2020	Joint Unit for DVA/SVA/VAWG	Improved practitioner and public awareness of child-parent abuse	Track number and source of referrals, including self-referrals, into specialist domestic abuse services, incorporated into contract monitoring and KPIs	
3	**East Sussex Safer Communities Partnership should increase public awareness about child-parent abuse and the role of specialist domestic abuse services in supporting those affected**	CSP agency reps to include information about child-parent abuse with information and links to specialist domestic abuse services and Home Start on public facing online and social media platforms	CSP rep online platforms and social media updated with information specific to child-parent abuse with contact details for specialist domestic abuse services and services that can support.	Jan 2022	CSP reps		As a result of more integrated, holistic assessments where issues and vulnerabilities are not viewed in isolation, multi-agency responses might be indicated alongside an awareness that economic abuse as a probable	

							indicator of other abusive behaviours.	
		Awareness raising campaign of child-parent abuse to be incorporated within the East Sussex White Ribbon Action Plan and promoted during the 16 days of action events on an annual basis	White Ribbon plan updated and finalised Events planned for white ribbon to promote awareness with the public to include CSP agencies and community organisations	Dec 2021	Joint Unit for DVA/SVA/VAWG	Increased recognition of child-parent abuse in the community and amongst the public and breaking down of stigma and barriers to reporting	Monitor referrals into agencies, including ASC, CS, SPFT, Sussex Police and specialist domestic abuse service of child-parent abuse	
		Promote services to support victims of child-parent abuse in a way that addresses the isolation, stigma, shame, guilt and fear as particular barriers for parents in seeking help		Dec 2021	CGL	Parents know how to reach out for support and that the support is offered in a non-stigmatising way	Monitoring of self-referrals into CGL for child-parent abuse Track responses to service user feedback regarding child-parent abuse with CGL including narrative within contract monitoring reports	
		Include raising awareness of child-parent	Action Plan updated	Oct 2021	Strategic Commissioner for DVA/SVCA/VAWG	Increased support and safety for	Monitoring of East Sussex Domestic	

		abuse with the public and support available within East Sussex Domestic Violence and Abuse Action Plan				victims of child-parent abuse	Violence and Abuse Action Plan	
OVERVIEW RECOMMENDATION 4: Pre-Sentence Reports for Domestic Abuse Offences (National)								
4	**The Ministry of Justice is asked to consider whether a standard should be set for pre-sentence reports involving domestic abuse, including those pre-sentence reports which are required verbally and 'on the day', to routinely include evidence of police reports, necessitating the time being allocated for them to be carried out.**	The Chair of the Safer Communities Board to write to the Victims Lead, MOJ and notify of this recommendation, requesting a response in order to update this multi-agency action plan.	MOJ notified of this recommendation and response received.	Dec 2020	Chair of the Safer Communities Board	Perpetrators are held to account for their actions and Court judgements and decisions adequately manage the risk posed by perpetrators and increase safety to victims	Monitoring would need to be confirmed by the MOJ	

APPENDIX 2: HOME OFFICE FEEDBACK LETTER

Interpersonal Abuse
Unit 2 Marsham Street
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NG
Strategy and Partnership Officer
Domestic Abuse, Sexual Violence and Abuse & Violence against
Women & Girls Joint Unit
Brighton & Hove & East Sussex

31 October 2023

Dear NG,

Thank you for resubmitting the report (Adult K) for East Sussex Community Safety Partnership to the Home Office Quality Assurance (QA) Panel. The report was reassessed in November 2021. I apologise for the delay in responding to you.

The QA Panel felt the DHR was thorough, well-structured, and well written. It is open and non-defensive, presenting a good summary of events which makes it clear to read and easy to follow. The inclusion of research is commended as one of the review's strong points and highlights important domestic abuse (DA) related issues, allowing agencies understanding of DA and familial abuse to be challenged. The DA expertise of the chair is evident throughout the review.

The equality and diversity section explores the mother-son relationship well and also considers socio-economic factors which is highlighted as good practice. The identification of possible unconscious bias on the part of agencies and professionals involved is an important feature and speaks to the imperfect understanding professionals demonstrated around economic abuse. The

intersectionality of drugs, alcohol misuse and mental health is also set out clearly, as is the need to recognise and manage the added risks that these present, both to the individuals using /experiencing them and the impact on others. The review presents missed opportunities for action or learning for the future, including a list of possible DA missed opportunities as well as mental health referrals and other failings.

The Home Office noted that although some of the issues raised in the previous feedback letter have not been addressed, in the interest of time and to give the family a sense of closure the report may be published.

There are also a number of points that the Home Office would like the CSP and Chair to note:

The format of the report does not follow Home Office guidance resulting in it feeling disjointed.

- The resubmission contains many typos that still haven't been amended. The report requires a thorough proofread with typos and grammar issues
  amended prior to publication.

- The DHR would benefit from including details from the perpetrator's
  psychiatric report for the court (a) to increase learning as such reports usually include valuable background, and (b) to help the reader understand the sentence of the court.

- The DHR should do everything possible to avoid calling the victim 'victim' throughout the Review instead of using a pseudonym. In addition to the lack of additional description of the victim in this Review, by using the term 'victim' she feels dehumanised. The front page of the Review also refers to the 'death of a woman' which again diminishes her status. Families should be offered the opportunity to choose a pseudonym to anonymise the reports, but if they feel unable to the Panel should choose one and then this checked with the family for suitability.

Once completed the Home Office would be grateful if you could provide us with a digital copy of the revised final version of the report with all finalised attachments and appendices and the weblink to the site where the report will be published. Please ensure this letter is published alongside the report.

Please send the digital copy and weblink to DHREnquiries@homeoffice.gov.uk. This is for our own records for future analysis to go towards highlighting best practice and to inform public policy.

The DHR report including the executive summary and action plan should be converted to a PDF document and be smaller

than 20 MB in size; this final Home Office QA Panel feedback letter should be attached to the end of the report as an annex; and the DHR Action Plan should be added to the report as an annex. This should include all implementation updates and note that the action plan is a live document and subject to change as outcomes are delivered.

Please also send a digital copy to the Domestic Abuse Commissioner at DHR@domesticabusecommissioner.independent.gov.uk

On behalf of the QA Panel, I would like to thank you, the report chair and author, and other colleagues for the considerable work that you have put into this review.

Yours sincerely,

Lynne Abrams

Chair of the Home Office DHR Quality Assurance Panel