Shropshire Safeguarding Community Partnership

Shropshire

Safeguarding Community Partnership

Domestic Homicide Review

Under section 9 of the Domestic Violence, Crime & Victims Act 2004
into the death of:

Mr C (who died in September 2021)

Independent Chair & report author: Kevin Ball

Date: June 2024

Final Version incorporating Home Office Quality Assurance Panel final feedback.

1. Introduction to the case subject to review

1.1. This Domestic Homicide Review examines the contact and involvement of professionals and organisations with Mr C. Mr C was 80 years of age, and was of white British ethnicity. Mr C tragically died in hospital as a result of injuries sustained from an altercation with his grandson two days earlier in September 2021. Mr C has been described by one close family member as 'meaning the world' to them and 'being very caring'. One long standing friend described Mr. C. as a 'lovely character, and the life and soul of a party' and is missed by all of his close friends and family.

1.2. The Domestic Violence, Crime & Victims Act 2004 sets out the circumstances when a Domestic Homicide Review should be considered when the death of a person aged 16 years or over has, or appears to have, resulted from violence, abuse or neglect by a) a person to whom he/she was related or with whom he/she had been in an intimate personal relationship, or b) a member of the same household as himself/herself. Based on statutory guidance[1], the purpose of any Domestic Homicide Review 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.

1.3. Domestic Homicide Reviews are not inquiries into how a person died or who was responsible for the death; those are matters for Coroners and criminal Courts respectively to determine. A subsequent Police investigation and criminal trial took place in December 2021. Mr. C's grandson, to be known as Adult B, pleaded guilty to manslaughter and was sentenced to three years in prison; Adult B's ethnicity is white British, and he was aged 32 years.

2. Methodology for conducting this review, including terms of reference & contributors to the review

2.1. Using the criteria detailed above, Shropshire Safeguarding Community Partnership were notified about Mr C's death on the 22nd September 2021 by the Police, and then following some administrative issues, re-submitted the referral on the 7th October 2021. The Partnership notified the Home Office on the 6th January 2022 about the intention to conduct a Domestic Homicide Review. This incident occurred during the Covid-19 pandemic and associated restrictions; invariably, this caused some delays to the usual processing of activities that needed to be taken. The following steps were then carried out by the Partnership;

a) Requests for initial information about any contact or involvement with Mr C and other relevant individuals were made to agencies in October 2021. Table 1 below provides details of those contacted at this initial stage.

[1] Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews, December 2016, Home Office.

Table 1: Agencies/Services contacted at the initial scoping stage	
Agency/Service	**Agency/Service**
Clinical Commissioning Group	West Mercia Police
Shropshire Council Children's Social Care	Midlands Partnership NHS Foundation Trust
Shropshire Council Adult Social Care	GP Practices x 2
West Midlands Ambulance Service	Wrexham Maelor Hospital
We are with you (Alcohol, drug & mental health)	Shropshire Fire & Rescue Service
Shropshire domestic abuse services (Connexus)	Department for Work & Pensions
National Probation Service	Robert Jones & Agnes Hunt Hospital Trust
Shropshire Community Health Trust	Shrewsbury & Telford Hospital Trust
ShropDoc (out of hours primary care)	Shropshire Council Housing Services
Shropshire Council Regulatory Services	Shropshire Recovery Partnership
West Mercia Women's Aid	-
Youth Justice Service	-

b) In February 2022, the Chair of the Shropshire Safeguarding Community Partnership appointed Kevin Ball as the Independent Chair and report author for this Domestic Homicide Review. He is an experienced Chair and report author, notably of cases involving the harm or death of children, but also more recently Domestic Homicide Reviews. He has a background in social work, and over 30 years of experience working across children's services ranging from statutory social work and management (operational & strategic) to inspection, Government Adviser, NSPCC Consultant and independent consultant; having worked for a local authority, regulatory body, central Government and the NSPCC. Over his career, he has acquired a body of knowledge about domestic abuse through direct case work, case reviews and audit, and research and training, which supports his work as a Chair and reviewer of Domestic Homicide Reviews. During his career, he has worked in a multi-agency and partnership context and has a thorough understanding about the expectations, challenges and strengths of working across complex multi-agency systems in the field of public protection. In the last 10 years he has specifically focused on supporting statutory partnerships identify learning from critical or serious incidents and consider improvement action. He has contributed to the production of Quality Markers for Serious Case Reviews, developed by the Social Care Institute for Excellence & the NSPCC – which are directly transferable and applicable to the conduct of Domestic Homicide Reviews. He has completed the Home Office on-line training for Domestic Homicide Reviews and the Chair training course provided by Advocacy after Fatal Domestic Abuse (AAFDA). He has no association with any agencies involved and is not a member of the Shropshire Community Safety Partnership. There is no conflict of interest.

c) Since April 2020 the adults and children's safeguarding arrangements in Shropshire have been amalgamated with the partnership arrangements for community safety, thus becoming a tripartite partnership which oversees the statutory functions of adults safeguarding, children's safeguarding and community safety. In March 2022, an initial Review Panel meeting was convened in order to provide oversight and scrutiny of the process, agree the Terms of Reference, offer relevant expertise and ensure the smooth and timely conclusion of the review. Table 2 below provides details about membership of the Review Panel.

Table 2: Review Panel membership

Name	Agency	Role
Kevin Ball	Independent	Independent Chair & author
Lisa Gardner	Shropshire Safeguarding Community Partnership, Business Unit	Development Officer
Paul Cooper	Integrated Care Board	Head of Safeguarding Adults
Steve Cook	West Mercia Police	Detective Inspector
Natalie McFall	Shropshire Adult Social Care	Assistant Director
Sonya Miller	Shropshire Children's Social Care	Assistant Director
Becky Dale	Probation Service	Deputy Head of Service
Rabinder Dhami	Fire & Rescue Services	Prevention Manager
Duncan Kett	Midlands Partnership NHS Foundation Trust	Head of Safety & Risk Management
Wendy Bulman	Shropshire Domestic Abuse Service (SDAS) at the start of the review, and then Shropshire Council	SDAS Manager & then Domestic Abuse Strategic Lead
Nicola Albutt	West Midlands Ambulance Service	Safeguarding Manager
Alex Leeder	Drug & Alcohol Services	Drugs and Alcohol Development Officer

e) Following the initial Review Panel meeting in March 2022 the Independent Chair contacted family members, initially by letter to explain the review process and offer them the opportunity to contribute to the review.

f) The following Terms of Reference, and lines of enquiry were agreed by the Review Panel in March 2022:

1. Each relevant agency's contact and involvement with relevant members of the family from January 2015 up to September 2021. January 2015 has been chosen as a point where it is understood that Adult B formed a relationship with a female who had two children. Importantly, any relevant information prior to this period should be included in any agency submissions.

2. To examine whether Mr C had any identified needs, and whether agencies and services were addressing those identified needs; if not, whether this made him more vulnerable.

3. To capture any concerns from family members, friends or the community about the quality of the relationship between Mr C and Adult B.

4. To capture any concerns from family members about access to services for Mr C in order to meet any identified needs, plus any insights into the quality and effectiveness of any services that he did access.

5. To explore the quality and effectiveness of agency/service response to Adult B regarding any reported incidents of domestic abuse with former, or current partners, and consider any children living in the same household. In doing so, issues around information sharing, risk to others, and risk assessment/management should be examined. This should include consideration about the contributions of the Multi-Agency Risk Assessment Conference (MARAC)[2].

[2] MARAC - The Multi-Agency Risk Assessment Conference is a regular meeting where agencies discuss high risk domestic abuse cases and develop a coordinated safety plan for the victim and his or her children. Agencies taking part may include Police, Independent Domestic Violence Advisors (IDVAs), Children's Social Services, Health Visitors and GPs, amongst others.

6. To explore the quality and effectiveness of agency/service response to Adult B regarding any mental health (including self-harm) or alcohol misuse difficulties he may have experienced. In doing so, issues around information sharing, risk to others, and risk assessment/management should be examined.

7. To examine whether Covid-19 restrictions had an impact on circumstances and events.

8. To examine whether there were any issues in relation to the nine protected characteristics under the Equality Act 2010 (age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, sexual orientation).

9. The impact of organisational change over the period covered by the review for any services which came into contact with relevant family members; whether this was a contributing factor in service delivery, and how this impacted on the service provided to any member of the family.

g) Table 3 below, provides details about those agencies/services that were asked to submit Individual Management Reports. All of the authors of the IMRs are individuals with special responsibility for statutory reviews within their organisations (usually senior managers) who had no direct involvement with any of the principle subjects in this DHR. Each IMR is quality assured by another senior manager prior to being sent to the Business Unit and the author.

Table 3: Agencies/services asked to submit an Individual Management Report
West Mercia Police
Midlands Partnership NHS Foundation Trust
Wrexham Maelor Hospital
Shropshire Domestic Abuse Service (Connexus)
West Midlands Ambulance service
Shropshire Recovery Partnership (We are with You)
Shropshire Council Children's Social Care
Shropshire Council Adult Social Care
GP Practices x 2 (Mr C's & Adult B's)

h) The Review Panel met to examine information provided by the IMRs in early May 2022. Further Review Panel meetings were scheduled as necessary; with additional Review Panels being held in June and August 2022.

i) Access to statements taken by the Police was provided to the Chair by the Police, following the conclusion of the criminal trial. This included statements from family members, as well as friends and neighbours of Mr C.

j) Family members, notably Adult B and Mr C's adult children were offered the opportunity to contribute to the review.

k) The final report was presented to the Shropshire Safeguarding Community Partnership in December 2022. The review process took just over 12 months to complete, six months longer than the indicative timescales of six months. The reason for this is due to the delays in waiting for the criminal investigation and trial to conclude. The report was then submitted to the Home Office Quality Assurance Panel, who undertook their review of the draft report and provided feedback in September 2023. Further changes were made, and the Home Office Quality Assurance Panel completed their final feedback and permission to publish the report on the 3rd June, 2024.

l) The content of the overview report and executive summary have been anonymised in order to protect the identity of the victims, perpetrator, relevant family members, and others, and in order to comply with the Data Protection Act 1998. In order to secure agreement, pre-publication drafts of this overview report were seen by the members of the Review Panel, and the Shropshire Safeguarding Community Partnership. It has also been shared with the Home Office

Quality Assurance Group. This overview report and executive summary will be made public, and the recommendations will be acted upon by all agencies, in order to ensure that the lessons of the review are learned. It will be disseminated to the following:

- Director of People, Shropshire Council
- Local Policing Commander Superintendent, West Mercia Police
- Detective Superintendent, West Mercia Police
- Executive Director for Quality, Clinical Commissioning Group
- Head of The Probation Service
- Prevention and Protection Manager, Shropshire Fire and Rescue Service
- Director of Public Health, Shropshire Council
- Chair of Tackling Drug and Alcohol Misuse Priority Group
- Chair of Tackling Exploitation Priority Group
- Chair of Local Domestic Abuse Partnership Board
- Cllr Simon Jones/ Celia Motley (Portfolio Holder for Adult Social Care, Public Health and Housing)
- Nicole Jacob - Domestic Abuse Commissioner for England and Wales
- John Campion – West Mercia Police and Crime Commissioner

m) The detailed findings of all information provided to the review remained confidential. Information was available only to participating officers / professionals and their line managers. A confidentiality agreement was agreed by DHR Panel members at the commencement of the DHR and reconfirmed at the start of each Panel meeting.

2.2. The review has kept in mind the nine protected characteristics of the Equality Act 2010 (age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, sexual orientation). The characteristic of age, given Mr C age, has been held in mind as being relevant to this review. All other protected characteristics have been reviewed, including sex and not considered to have had a significant relevance. Whilst both victim and perpetrator were male the most consequential determinant of this catastrophic outcome was based on the actions of Adult B owing to the familial connection. The age of Mr C and his related physical health conditions meant he was less physically robust than his grandson who was the assailant attacked him.

3. Family, friends and other's contribution to the review

3.1 Mr C had lived alone in his home since the death of his wife a few years previously. He was described as fiercely independent and would spend time with his friends in the pub on a weekend playing dominoes. Mr C cared deeply about his family and had three children from two marriages. He also had a number of grandchildren who would visit him at his home. We have been informed that since his wife's death his daughters had been doing some of his cleaning and other odd jobs for him however, he liked to do as much as he could for himself.

3.2 Adult B is the child of Mr C's eldest daughter. Adult B's childhood was turbulent and in his early teens he spent a short period of time living with Mr C and his wife due to family breakdown. Mr C was a stable and consistent figure in Adult B's life. There are a number of interpersonal relationships that will be discussed in more detail, due to their relevance to this review, later in this report.

3.3. Seeking the contributions of family, friends and those that knew Mr C has been an important consideration for this review. Family members have, understandably, found the whole situation very difficult to come to terms with.

3.4. Three separate family members were offered support via the Victim Contact Scheme during the Police investigation and trial, however no family members took up this offer.

3.5. All family members were notified by letter that the review was going to be undertaken and offered the opportunity to speak with the Development Officer and Author. The letter was followed up by a telephone call to explain the process and offer the opportunity to engage with the review at all stages. One of Mr C's adult children confirmed that they did not wish to contribute to the review via a very brief email exchange. Two of Mr C's adult children confirmed that they did wish to contribute to the review. Only one subsequently communicated with the Chair, despite attempts to engage both. The final report was shared with this family member. Family members were offered the opportunity to choose pseudonyms but declined with no strong view.

3.6. The Chair offered Adult B the opportunity to contribute to the review, which was taken. As such, the Chair spoke with Adult B via video link, with the Development Officer from Shropshire Safeguarding Community Partnership Business Unit also attending. Adult B declined the opportunity to see a copy of the final report.

3.7. Adult B's history of domestic abuse behaviours with intimate partners has been reviewed with information received from various sources noting some constructive interventions were attempted, but with limited positive impacts.

3.8. Statements taken by the Police as part of their investigation were also examined, which prompted the Chair to seek the contributions of one of Mr C's long-standing friends. Attempts were made to gain the contributions of another friend, however this proved unsuccessful. These contributions about Mr C have been hugely helpful in gaining a better sense of who Mr C was and his relationship with the perpetrator.

4. Chronology

4.1. For the purposes of this report, the following individuals are of interest:

- Mr C – the victim and subject of this review
- Adult B – the perpetrator and grandson to the victim

4.2. Following a report of fighting between Adult B and Mr C the Police attended Mr C's home in September 2021. On arrival it was clear to the Police that Mr C had sustained a head injury from being pushed to the floor, which required medical attention. Mr C told Police that an argument had begun with Adult B about his Will and what money Adult B might be entitled to. Adult B had been drinking alcohol and left the property in Mr C's car. A 999 call was made by the Police in attendance, requesting medical assistance due to a head injury. Approximately 2 hours and 20 minutes later a paramedic from the West Midlands Ambulance Service control room contacted the patient, and a telephone assessment completed via one of Mr C's adult daughters who was also at the property; this resulted in an agreement that the patient (Mr C) would be taken to hospital by a family member to reduce the need to wait for an ambulance, and therefore the dispatch of an ambulance was not required. This did not happen and consequently Mr C did not receive any medical treatment for his injuries, as Mr. C expressed a view that he did not want to go to hospital.

4.3. An investigation was commenced and a DASH assessment[3] (Domestic Abuse, Stalking & Harassment) completed graded as 'medium risk'. Adult B was arrested the following day, interviewed and released on Police bail until the end of September pending further investigative enquiries into the assault.

4.4. A day later, the Welsh Ambulance Service was contacted via a 999 call from a third party, reporting that Mr C could not be woken. An ambulance was dispatched from the West Midlands Ambulance Service. Due to his unsteady and unresponsive condition, he was taken by ambulance to Wrexham Hospital. The following day, Mr C died. It was

[3] DASH assessment - The purpose of the DASH Risk Assessment is to give a consistent risk assessment tool for practitioners who work with adult victims of domestic abuse. It's used to help practitioners identify those who are at high risk of harm and whose cases should be referred to a MARAC meeting in order to manage their risk.

suspected that Mr C's death resulted from the injuries sustained two days earlier. Subsequently Adult B pleaded guilty to manslaughter and was sentenced to three years in prison.

4.5. From review of submissions by agencies and services, Mr C had no, or very limited contact with the majority of those agencies that contributed to the review. Mr C was known to his GP who detailed that he had significant health problems; chronic obstructive pulmonary disease (COPD), ischaemic heart disease and heart valve problems. He had heart surgery in 2016 and was on an anticoagulant medication because of his heart problems. He was in regular contact with the GP surgery.

4.6. Further information has been captured about Mr C from family, friends and neighbours, via Police witness statements. One family member described Mr C *'… as a helpful man, he had a heart of gold. He helped a lot of people in different ways over the years both inside and out of the family. Always ready to do a favour for anyone … Mr C's relationship with his grandson has been up and down big time. Adult B was always wanting money off Mr C. I expect this was to buy beer & cigarettes. Adult B would always call Mr C asking if there was anything he could do to earn some money …'.*

4.7. A long-standing friend of Mr C's commented *'…I know Mr C's relationship with his daughters … was really good. Mr C's daughters would regularly visit to help out with chores. Mr C's relationship with his grandson, … was sometimes hot and sometimes cold … After learning of Mr C's death, I felt extremely sad and emotional … It made me angry as Mr C has done a lot for Adult B over the years …*'.

4.8. There is relevant information which is of interest to this review, involving Adult B and his substantial contact with the Police, and by implication, other agencies. This is relevant in the context of examining whether there is any learning for agencies and services.

4.9. Adult B has been known to the Police since he was 14 years of age, with him committing offences and being subject to criminal investigation and civil orders since 2003; offences included anti-social behaviour, allegations of theft, assault, criminal damage, and burglary. There were a number of multi-agency interventions to support Adult B and his family when he was a child as it was felt that some of the behaviours he was exhibiting were related to familial concerns. When Adult B spoke of his childhood to the author he identified that issues of parental separation created trauma and loss. There is evidence that as a response to this Adult B received multi-agency interventions from the Police, Education and Children's Services however the impact did not sufficiently alter Adult B's ability to regulate the behaviours that created concern.

4.10. As an adult, in 2010 Adult B was charged with assault and criminal damage against his mother and sibling. Adult B perpetrated abusive behaviour within his intimate relationships between 2010 and 2021, including hitting, biting, stalking and harassment, threats to kills, non-fatal strangulation, damage to property and was known to be highly controlling and coercive. Interventions included partners being referred to Multi Agency Risk Assessment Conferences (MARAC), being subject to Police risk management plans, being protected by a Restraining Order and having to flee to a Refuge, Strategy[4] meetings and Children's Services assessments. Adult B was imprisoned as a result of his abuse to an intimate partner.

4.11. In 2018 Adult B was referred by his GP to the Community Mental Health Team (a service run by the local specialist mental health NHS Trust) for depression and anxiety, self-harming thoughts and alcohol misuse; he did not accept an offer of counselling but did present to the Mental Health Team three times, including on one occasion when he had

[4] Strategy meetings held under section 47, Children Act 1989 where a local authority have reasonable cause to suspect that a child who lives, or is found, in their area is suffering, or is likely to suffer, significant harm, the authority shall make, or cause to be made, such enquiries as they consider necessary to enable them to decide whether they should take any action to safeguard or promote the child's welfare.

taken an overdose of tablets. He did participate with a detox programme in May 2018, and prescribed medication to help his alcohol use as well as anti-depressants. He continued to misuse alcohol and did not consistently use his medication – thereby reducing the effectiveness of his treatment and resulting in him being more unpredictable. Between 2005 and 2022, Adult B had a total of 14 convictions relating to 27 different offences, many of which involved alcohol misuse, criminal damage, and assault. Mr C was victim of two of these offences in 2006, when Adult B firstly stole a road tax disc from Mr C's car, and then later in the year took Mr C's car without consent. At the time of the car being taken, Adult B was on Court bail to reside at Mr C's address and subject to overnight curfew arrangements.

4.12. In June 2021 the Police received a 999 call from a member of the public concerned about seeing Adult B sitting on the wrong side of a viaduct railings. Police attended the scene, noted that Adult B had been drinking alcohol, commented on feeling low but that he did not intend to harm himself. He told Police that he was in regular contact with the Crisis Team but declined a further contact with them as he felt he did not get any support from the Crisis Team. The officers completed an Adult Protection Incident (API) which was graded as Standard Risk and forwarded to the Police Harm Assessment Unit (HAU). The API was reviewed by HAU and the information was not forwarded to other agencies. The rationale recorded that Adult B had shown no indication that he was suffering a mental health crisis or was a risk to himself or others. He was offered the opportunity to speak with the Crisis Team who he was already in touch with but declined. He was transported back to his father, and left in his care.

4.13. Later in June 2021 Police received two linked 999 calls reporting that Adult B had set clothing on fire outside a former partner's address, was intoxicated and had taken her car and driven away. Police and Shropshire Fire & Rescue Services attended the scene. Fire Services were first to arrive at the address and confirmed a fire had been started deliberately near to the front door of the address. Adult B was stopped by Police driving the vehicle but ran off before he could be detained. Later that day Police received a call via a 999 call about a further incident and assault involving Adult B. On Police arrival at the scene, Adult B ran away. There were further incidents later that night when the Police had left the location, when Adult B returned to the property causing more damage. This episode also resulted in Adult B being assessed under section 136 of the Mental Health Act when he was engaged by North Wales Police during, what appeared to be, a possible suicide attempt. This resulted in him being taken to a local hospital for assessment.

4.14. An electronic Risk Management Plan (RMP) was created on police systems to record information and collate local policing activities and agency information and updates. In early July 2021 the RMP was updated to record that Adult B had been arrested and was in custody. It was then further updated to record that Adult B was released on conditional Police bail which included conditions to safeguard a former partner by prohibiting contact. The former partner was not supportive of any prosecution of Adult B in respect of coercive and controlling behaviour and she did not see herself as a victim. A further supervisory review recommended that the Police investigation was not taken any further, in part due to evidential difficulties, which included not being able to take forward an evidence-led prosecution. The RMP ran from the end of June 2021 until September, when it was reviewed and closed following the charge and remand of Adult B following Mr C's death.

5. Findings & analysis

1. As set out in section 1.3, the purpose of this review is to establish any lessons to be learnt regarding the way in which local professionals and organisations worked individually and together, begin the process of improvement activity based on lessons learnt, and support a preventative and coordinated approach to identifying and responding to domestic abuse.

2. Mr C's GP has described Mr C as very independent; if he wanted something, he was very capable of being assertive and ensuring that his wishes were addressed and usually got his "own way". Other information submitted and contributions from family and friends confirms this view also noting he was highly sociable with local long-standing

friendships and someone who cared about his family. One friend described Mr C as being helpful to him and his wife when he'd been ill by visiting him. He also spoke fondly about playing golf, playing cards and dominos, and having a really good laugh with Mr. C. The friend described Mr C as someone who would 'help you rather than hinder you'. He would often sound exasperated about what his grandson might have been up to but never moaned about him; he would keep his private thoughts to himself.

3. Whilst it is recognised that this is the subjective view of a perpetrator, Adult B described his relationship with his grandfather positively, detailing that he acted like a father to him when growing up, showing him how to use tools, play golf and go fishing travelling around the country to different places. He also spoke fondly about going to the pub with him, and with Mr C's friends and learning how to play pool or cards with that friendship group. Adult B's view is that the relationship was supportive and that he used to visit him regularly. He spoke about looking out for him, and not wanting some, more distant family members, to take advantage of him. Adult B regarded Mr C as a strong and independent source of support.

4. Mr C had significant health problems; no doubt exacerbated by his advancing age – however, there is nothing to indicate that his age was an overly restrictive factor in his life. His contact with agencies and services was minimal and records indicate that this wholly related to his health conditions and treatment. He regularly had contact with family members, which are reported as being positive and caring. The exception to this, was his relationship with his grandson, Adult B, which – based on accounts provided – might be described as inconsistent.

5. There is no information which indicates Mr C was in a domestically abusive relationship with anyone else; his wife (Adult B's grandmother) died some years earlier. In terms of Mr C being a victim of domestic abuse, the statutory definition[5] of domestic abuse has been considered against the known circumstances of this case. Whilst it is clear that Mr C and Adult B were 'personally connected'[6] due to being relatives, and both were over 16 years of age, it is difficult to conclusively argue that the relationship between Adult B towards Mr C was overtly systematically abusive, especially in terms of Adult B's behaviour being controlling or coercive or there being sustained economic abuse[7] - as referred to by a family member about Adult B always wanting money. There is however no information to indicate that these acts, or requests, by Adult B, had a substantial adverse effect on Mr C's ability to control his own financial affairs or that he was being financially abused in a routine or systematic way. It is Adult B's view that Mr C was never put under pressure by him, to give him money. He contends that arguments did happen with family members when Adult B felt that Mr C was being taken advantage of, especially over money matters. However, it is recognised that this is Adult B's perspective and therefore by nature is deeply partial, subjective and potentially self-serving. The information available from other sources who had a positive relationship with Mr C was that Adult B recognised that if he wished to receive money from his Grandfather, he would have to earn it by performing jobs. Therefore, there was no evidence from Mr C's family or friends that either financial or economic abuse appears to be a regular feature in this case and there were no reports of any agencies receiving concerns to this effect.

6. It appears that Mr C, tragically, was the victim of Adult B's unprovoked attack at that moment in time – being pushed and sustaining injuries which ultimately resulted in his death; this is reflected in the conviction of manslaughter. It may be argued that Adult B's behaviour towards Mr C was reflective of similar negative behaviours displayed towards former female partners. Without gaining Mr C's perspective about what it felt like to be on the receiving end of Adult B's behaviour at that time, it is not possible to offer an alternative perspective.

[5] Domestic Abuse Act 2021, section 1 & 2.

[6] Domestic Abuse Act 2021, section 4 – definition of personally connected.

[7] Domestic Abuse Act 2021, section 1 (3, d) & 4.

7. Given the guilty plea by Adult B, no psychiatric reports were commissioned for the criminal trial; as such, there is no expert opinion to examine in order to better understand motivating factors and profile.

8. Therefore, in undertaking this review which examines Mr C as the victim, it is clear that there is very little information to examine from an agency perspective which provides insights into the relationship problems between Mr C and Adult B – this hampers our ability to identify lessons to be learnt, and the findings and analysis of the review will therefore, inevitably, be limited in this particular respect.

9. Notwithstanding this, questions have to be raised about whether other information was known, or was knowable, that might have indicated Adult B posed a risk to others, and whether it would have been reasonable for this to be used by agencies and services to prevent future harm. Such questions invariably raise consideration about preventability and predictability – but these issues are not within the remit of a Domestic Homicide Review.

10. As detailed above, there is significant information available about Adult B and risks he posed. By proportionately analysing this information, and being curious about how it might have been used, the review can consider whether there were implications for Mr C's safety, and respond to the specific lines of enquiry that were established.

5.1. To examine whether Mr C had any identified needs, and whether agencies and services were addressing those identified needs; if not, whether this made him more vulnerable.

5.1.1. Mr C had significant identified health needs; he did not however have any identified care or support needs. Records examined from those agencies that were responding to his health needs i.e., GP Practice, Adult Social Care (Occupational Therapy Services), and Betsi Cadwaladr University Health Board, show that his health needs were being met through regular and scheduled attendance at appointments, the provision of prescribed medication, and review. No safeguarding concerns have been identified at any point during the interactions between Mr C or any professional from a health agency or discipline, and Mr C did not raise any worries or concerns of a safeguarding related nature to any practitioner he came into contact with. From a GP Practice perspective, Mr C was a regular attender at the Practice prior to Covid-19 restrictions; and clearly during the pandemic his attendance reduced. He was last seen at the Practice in August 2021 for a scheduled health appointment. Mr C's health needs were therefore being met.

5.1.2. By virtue of his age, alongside his considerable health needs, Mr C was somewhat inherently vulnerable. However as noted earlier his GP, who knew Mr C well commented that; if he wanted something, he was very capable of being assertive and ensuring that his wishes were addressed and usually got his "own way". There was no information presented which indicated that Adult B systemically preyed on, or exploited, any vulnerability that Mr C may have had.

5. 2. To capture any concerns from family members, friends or the community about the quality of the relationship between Mr C and Adult B.

5.2.1. From review of statements taken by the Police it is clear that two close acquaintances/family members were aware of some difficulties between Mr C and Adult B, inasmuch that it was known that the relationship was a frustrating one. However, as noted, accounts from one long standing friend conveyed this as more of a sense of frustration and exasperation about 'what the hell is he up to now' rather than anything more negative regarding ongoing systematic abuse. No other statements taken indicated any problems. Gaining these two separate views, post Mr C's death, has to be considered in the context of hindsight bias – a bias that the individuals who provided these statements to the Police knew that Mr C had been harmed and had died as a result of Adult B's actions, and this potentially influencing their thinking and recall. It is not possible to know what views they may have expressed about the quality of the relationship had there been no critical and fatal incident. Neither of these witnesses, in their recall, spoke about the difficulties being at such a level that they were worried or concerned for Mr C's safety or welfare, or that Adult B had ever physically harmed or assaulted Mr C.

5.2.2. Mr C's eldest adult child did worry about Adult B visiting her father when intoxicated and referred to Adult B drinking any alcohol in Mr C's house. It was felt that given Mr C's limited contact with agencies, which was confined to health professionals, there was nothing else anyone could have done differently for Mr C; there were no concerns known that warranted any intervention.

5.3. To capture any concerns from family members about access to services for Mr C in order to meet any identified needs, plus any insights into the quality and effectiveness of any services that he did access.

5.3.1. In discussion with family members about Mr C's needs it was confirmed that they felt their father was having his health needs met, and that no further or different intervention was needed. They did not view him as having care or support needs. Adult B also expressed a view that Mr C was having his needs met, and he was not aware of anything that Mr C needed, that was not already being provided.

5.4. To explore the quality and effectiveness of agency/service response to Adult B regarding any reported incidents of domestic abuse with former, or current partners, and children living in the same household.

5.4.1. The involvement and actions of each agency in respect of Adult B, will be examined.

5.4.2. *West Mercia Police:* West Mercia Police have identified a number of opportunities in their contact with Adult B between 2015 and 2021, that warrant comment. These include;

- The majority of incidents attended during this period which were of a domestic abuse nature were graded as 'medium' risk using the DASH assessment. There were two exceptions to this in March 2017 and June 2021. These two resulted in referrals to MARAC.

- Whilst policy, procedure and expectations were followed with each incident, and matters dealt with effectively, other options were available which could have been considered as ways of dealing with the issues identified. These include, for example; the use of Domestic Violence Protection Orders, consideration of powers under the Harassment Act 1997, the use of disclosure under the Domestic Violence Disclosure Scheme, the earlier use of Risk Management Plans, more extensive use of information about Adult B from more recent incidents on which to base risk assessment, and further onward referral to mental health services.

- Onward referrals were made by the Police to Children's Social Care & health agencies; these resulted in information being shared, multi-agency triage meetings (Domestic abuse Triage meetings) being held. There was one exception to this, which has been highlighted by Children's Social Care in relation to the Strategy meeting held in June 2021 where Adult B's full background of offending was not disclosed. In exploring this, it appears this was an isolated incident and not a systemic issue.

5.4.3. West Mercia Police have also identified areas where there were difficulties in their contacts, these include;

- Adult B's victims often did not feel able to, or felt insufficiently supported to, follow through their complaints or disclosures; this limited the Police's ability to deal with Adult B in a consistently robust way.

- The introduction of the Stalking Protection Act 2019 allowed for powers available to the Police to help victims of stalking; prior to this, provisions in the Harassment Act 1997 were not considered suitable to deal with first cases of harassment (which would have been the case on one particular occasion with a former partner).

- Changes over the timeframe which have impacted on workload i.e., in 2016 Domestic Abuse Risk Officers being proactive and being involved in the management of 'medium' risk cases, which has now shifted to 'high' risk cases due to increased workload.

- Changes in procedural expectations during the timeframe i.e., the use of Adult Risk Assessments in respect of Adult B. This became standard procedure in December 2018 in West Mercia Police. This would have allowed the Harm Assessment Unit to better assess whether a statutory multi-agency referral is required. In this case, it related to Adult B's behaviours and mental health difficulties. This finding has highlighted inconsistencies about when information is shared with other agencies based on an interpretation of the Care Act 2014 definition of 'adult at risk'[8] versus the National Police Chiefs Councils definition of vulnerability[9]. These differences impact on training provided to Police Officers. In turn, this has impacted on whether incidents are recorded as 'Adult Protection Investigations' and communicated as such, to attending officers on any subsequent call-outs. Also, this impacts on the ability to see an emerging chronology of adult protection/adult vulnerability incidents; in this case, the emerging pattern of mental health episodes attended by the Police regarding Adult B would have been relevant to consider from this perspective, i.e., there being three within a two-month period.

- The procedural change relating to whether daily checks are carried out by the Harm Assessment Unit to capture incidents that may need the Unit's input such as domestic abuse, sexual offences, child related incidents or assaults. Previous to the incident which resulted in Mr C's death in September 2021 daily checks were not being completed; this has now changed and daily checks and cross referencing is carried out and the incidents involving Adult B earlier in 2021 would have been picked up, and collated by the Harm Assessment Unit.

- Sharing of intelligence across Police borders i.e., North Wales Police versus West Mercia Police. The sharing of information remains a perennial challenge for all agencies with public protection responsibilities.

5.4.4. *Adult Social Care:* Adult B was assessed under the Mental Health Act in July 2021 in a neighbouring local authority area. During the assessment interview he told the practitioners that he had been arguing with his partner who he said was pregnant with his child and that he felt protective towards her. The assessment report was shared with Shropshire Adult Social Care across the border, as well as Children's Social Care as a matter of routine but there was no checking against whether the agreed actions had been completed by Shropshire Adult Social Care. This has been identified as a system processing error, and one which has now been rectified by a duty worker now needing to undertake checking back against actions. At the time of the assessment, Adult Social Care identified no risk to others, just risk to self, due to Adult B's reliance on alcohol.

5.4.5. *Shropshire Domestic Abuse Services:* Shropshire Domestic Abuse Service have identified that a DASH risk assessment relating to Adult B was not completed on first contact with a former partner in August 2021. Instead, a risk tracker for those service users wanting only group work was completed, rather than an individualised approach through 1:1 outreach work (the former partner only wanted to access group work). The reason for this appears to be due to a simple miscommunication. This meant that issues relating to Adult B's mental health, and his drug/alcohol misuse could have been captured in August 2021 by the Service; this lapse resulted in not catching the potential higher risk and need to inform other agencies of the risks.

5.4.6. Adult B's GP: From Adult B's GP's perspective, they were not aware of any risk he may have posed to other's; they were only aware of risks he posed to himself. This has prompted the GP Practice to promote awareness about

[8] Care Act 2014, section 42, Safeguarding adults at risk of abuse or neglect: '*This section applies where a local authority has reasonable cause to suspect that an adult in its area (whether or not ordinarily resident there) - (a) has needs for care and support (whether or not the authority is meeting any of those needs), (b) is experiencing, or is at risk of, abuse or neglect, and (c) as a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it. (2) The local authority must make (or cause to be made) whatever enquiries it thinks necessary to enable it to decide whether any action should be taken in the adult's case (whether under this Part or otherwise) and, if so, what and by whom. (3) 'Abuse' includes financial abuse; and for that purpose, 'financial abuse' includes - (a) having money or other property stolen, (b) being defrauded, (c) being put under pressure in relation to money or other property, and (d) having money or other property misused*.

[9] National Police Chiefs Council definition of ' A person is vulnerable if, as a result of their situation or circumstances, they are unable to take care of or protect themselves or others from harm or exploitation.'

thinking wider than the presenting patient and consider family members. Review Panel discussions explored whether the GP (and more broadly) GPs should be provided with additional information about individual's, especially where they may present a risk to others. In some scenarios, for example, Section 47 (Children Act 1989) enquiries by Children's Social Care where there are concerns about a child's safety and welfare, the GP will automatically be invited to attend a Strategy meeting. Whilst they may not attend, they have been invited, but will not necessarily be informed of the outcome of the Strategy meeting or the conclusion of the enquiries. This may be an area that the Partnership wish to consider examining further; in this case, had information been shared, Adult B's GP would have been alert to the domestic abuse issues. Similarly, information from MARAC's does not necessarily or consistently get shared with GPs. This matter has been subject to recent discussion by the local Domestic Abuse Partnership Board The current MARAC protocol advises that the MARAC Co-ordinator shares information to the Safeguarding Co-ordinator in the Clinical Commissioning Group, and it is then further disseminated as appropriate. Discussions are being held about whether the MARAC information can go directly to the respective GP to allow a timelier sharing of information.

5.4.7. Children's Social Care: Children's Social Care have identified that at the point a Strategy meeting took place in June 2021 following incidents involving Adult B and a former partner, historical concerns were not presented by the Police and instead the meeting only considered the current issues. As noted above, information about Adult B's previous offending behaviours was not shared at this meeting; this has been described as a one-off error. The social work assessment that then went on to be completed in August 2021 '*was of poor quality, ignoring the voice of the child in its analysis and as such the decision to step down to Early Help could be called into question'*. The reasons provided for the error and poor quality have been cited as competency based and have been addressed. This highlights learning for both the Police, in needing to share all information, but also Children's Social Care needing to ensure good quality assessments on which to base decisions.

5.4.8. In summary, the quality and effectiveness of the response to Adult B regarding incidents of domestic abuse was inconsistent. Whilst there were elements of good, and expected practice, the Police, Adult Social Care, the Domestic Abuse Service, Children's Social Care and GP Practice have identified aspects of their service where improvements can be made. These improvements bare no direct relation to the interactions between Adult B and Mr C, and which lead to Mr C's death.

5.5. To explore the quality and effectiveness of agency/service response to Adult B regarding any mental health (including self-harming) or alcohol misuse difficulties he may have experienced. In doing so, issues around information sharing, risk to others, and risk assessment/management should be examined.

5.5.1. The involvement and actions of each agency in respect of Adult B, will be examined.

5.5.2. Midlands Partnership NHS Foundation Trust: Contacts and interventions with the Trust consisted solely of community-based services; there was no evidence that Adult B had any inpatient mental health episodes with the Trust. These consisted of:

- 2018: GP referral to Improving Access to Psychological Therapies (IAPT).
- 2018: GP referral to the Access Team. A triage of Adult B's mental health was undertaken and an onwards referral to the Trust's Non-Psychosis Pathway (now renamed the Community Interventions Pathway).
- 2018: Mental health assessment by the CIP: Adult B was discharged back to IAPT whom he was open to at that time with advice to engage in psychological based therapies and signposted to local recovery services.
- 2018: Assessment by the Liaison Mental Health Team (LMHT) based at Royal Shrewsbury Hospital (RSH) following an overdose of painkillers, with approximately 36 units of wine and superficial lacerations to Adult B's arm which did not require medical attention. Adult B's mental health was assessed by the LMHT and he was discharged to the care of his GP whilst agreeing to continue to having contact with the local alcohol recovery services and to utilise the Trust's Access Team for 24-hour support if required.

- 2018: Crisis Resolution and Home Treatment (CRHT): In November 2018 the CRHT were contacted by the local Police after the Police had undertaken a safe and well check. Adult B was provided with the team's contact details but did not contact them.
- 2021: In April 2021, Adult B's GP referred him to the Trust's Access Team following a self-reported incident of attempted suicide. During Adult B's contact with the Access Team, he denied any thoughts or plans of deliberate self-harm or suicide and agreed to re-engage with local alcohol recovery services and to be referred back into IAPT services.

5.5.3. Adult B's level of participation with MPFT's services was limited as he tended to have intermittent contact which did not last for any significant period of time. It was well documented that Adult B recognised the correlation between his alcohol consumption and his self-harming behaviours and threats to end his life. Adult B agreed to work with Shropshire Recovery Partnership, with the view of abstaining from alcohol however there was no evidence that he managed to achieve his goal of abstinence. In speaking with Adult B about his initial engagement and then, what appeared to be him not maintaining this, he spoke about it being challenging to follow up on appointments sometimes because he would either lose his mobile phone, or it was stolen, or he would have a new phone number – all resulting in his contacts being lost, and not being able to keep up with any messages. He also referred to living at different places, and not updating services with new addresses – thereby making it impossible for agencies to track his whereabouts. From Adult B's perspective, he commented that he felt he kept ringing to try to get help but acknowledged there were problems following this through.

5.5.4. Adult B was offered Cognitive behavioural therapy (CBT) by the Trust to treat / manage his diagnosis of depression and generalised anxiety disorder alongside pharmacological interventions from his GP which consisted of anti-depressant medication; these were in line with NICE Guidance Depression in adults: recognition and management (CG90) and Generalised anxiety disorder and panic disorder in adults: management (CG113). For Adult B's history of trauma, Eye Movement Desensitisation and Reprocessing (EMDR) had been considered as a treatment option by the IAPT service in line with NICE Guidance NG116 (Post –traumatic stress disorder: Management / Guidance). Adult B did not complete any structured treatment plan of care with the Trust's community mental health services.

5.5.5. West Mercia Police: As noted above, the Police did respond to five separate incidents where Adult B was believed to be at risk of self-harming (November 2018, two incidents in April 2021, two incidents in June 2021); which prompted them to complete a notification regarding Adult B being a vulnerable adult. As also noted above, this has highlighted learning in regard to the differences around definitions used, but also the timely sharing of information. The greater number of Police contacts were dealing with the victims of Adult B's behaviours.

5.5.6. During the first call-out in April 2021 the referral mentioned an incident a few days earlier during which Adult B had allegedly made an attempt to take his own life; the circumstances of this call-out appeared very similar. Analysis of the response to this incident has shown that information about the previous attempt was not shared with attending officers, but had it been, it would have highlighted an escalation and responding officers may have considered a referral to mental health services. Similarly, with the second incident in April 2021, although Adult B was spoken to twice over the phone by officers, the available recent history of previous contacts was not used to inform the assessment and decision making; consequently, there was no recognition about the possibility of Adult B's mental health deteriorating in recent days, and no onward referral to mental health services. The reasons given for these omissions relate to inconsistency of practice.

5.5.7. During the first call-out in June 2021, which appeared to involve Adult B considering harming himself, it was noted Adult B *'… was drunk, calm and quiet. He confirmed that he did not suffer with his mental health and does have days where he feels low and just wants time to himself … The officers recorded that they asked him if he wished to make contact with the Crisis Team and he declined stating he was in regular contact with them, however he told officers*

that he did not get any support from them …'. Again, analysis of this incident highlights that previous history was not examined or used within the assessment or decision making. A referral to the mental health team could have been made.

5.5.8. Combining, the above responses to Adult B's mental health crises consistently shows that previous specific chronological information about Adult B's mental health was not considered when assessing and making decisions about the best course of action. When placed alongside other information relating to call-outs for dealing with the victims of Adult B's behaviours, it becomes clear that opportunities were missed to share information with other agencies that might have resulted in Adult B being supported to access mental health services, or at very least, raised the profile of his mental health difficulties.

5.5.9. Adult Social Care: As detailed above, Adult B was assessed under the Mental Health Act in July 2021. The agreed plan was:

- Adult B to visit GP and discuss recent events and obtain prescription for anti-depressant medication.
- Referral to ACCESS- Shropshire mental health service- to manage low mood, develop more positive coping strategies, manage risk and referral for possible psychological input.
- Referral to Shropshire substance misuse services- for support around harmful alcohol use.
- Discharge off S.136
- A copy of this assessment will be sent to Children's Social Care in Shropshire due to Adult B's girlfriend having four children in household and is currently pregnant with his child

5.5.10. As noted, Adult Social Care have highlighted the importance of checking that agreed actions are carried out; in this situation, this did not happen. However, it is evident that other agencies and actions were followed through as other agencies were able to corroborate the action from their own records.

5.5.11. *Adult B's GP:* From Adult B's GP perspective, Adult B was open about his reliance on alcohol, self-harm and occasional suicidal ideation. However, the greatest concern seemed to be his ability to properly regulate his behaviours whilst under the influence of alcohol which then resulted in self-harm or suicidal ideation – and his inconsistency in seeking support. This made assessing risk problematic – often resulting in engagement and then not maintaining contact with services by Adult B; consequently, meaning he would often relapse. The GP Practice has highlighted aspects of good practice in their contacts with Adult B; namely being seen quickly when situations appeared to be emergencies, swift onward referrals to other support services, and the use of short courses of medication as viable treatment routes which avoided the use of medication which might be sedative or addictive in nature.

5.5.12. Shropshire Recovery Partnership: Shropshire Recovery Partnership have confirmed that Adult B had three episodes of treatment with them. His connectivity has been described as sporadic and limited - all service users are required to self-refer; thereby demonstrating self-empowerment, motivation and interest in wanting to make improvements in their lives. Adult B's inconsistency made it very difficult for this motivation to be sustained. As above, Adult B discussed the difficulties of not consistently having the same mobile phone or postal address and this affecting his capacity to attend appointments. One intervention did result in an in-patient detoxification programme that was initially successful but then followed by a relapse. The service has identified that they could have worked more effectively with other agencies, by sharing information – this is particularly so in respect of consistently sharing information with Adult B's GP. The reasons cited are due to a competency issue, which have since been rectified. This is however balanced with positive aspects of practice where information was properly shared with other services.

5.5.13. Children's Social Care: Children's Social Care were not directly involved in assessing or intervening with Adult B's mental health or alcohol misuse behaviours – they were however, dealing with some of the consequences as a result of his behaviours. As noted, the quality of information sharing, and social work assessment around June/July 2021 has been judged as poor and this reflects a missed opportunity for Children's Social Care to better understand

Adult B's behaviours, his own needs, and any risks he may have presented to other members of the children and families they were working with. The assessment opportunity would have permitted a legitimate reason to conduct further enquiries and obtain information.

5.5.14. If one were to adopt a trauma informed approach to considering the origins of Adult B's conduct and behaviours one might, not unreasonably, be curious about earlier adverse childhood experiences and how this might have impacted Adult B, and created a level of need, that went unmet. Based on Police records it is evident that Adult B had been known to the Police and other agencies since the age of 14 years; his conduct and criminal behaviours at that age will not have suddenly emerged, but, are likely to have been a consequence of earlier experiences which led him onto harmful pathways. In conducting a proportionate exercise, this review has purposely not sought detailed information outside of the agreed period of time (January 2015 - September2021) or to conduct a full review of the Adult B's earlier life experiences; it is nevertheless important to remain alert to identifying and responding to unmet childhood needs at the earliest opportunity, and adopting a preventative approach that is likely to have a longer term positive impact on children and their transitions into adulthood. Research[10] highlights five precursors to adult family homicide[11], including mental health and substance/alcohol misuse, criminal history, childhood trauma, financial factors, and care dynamics. Information submitted does indicate these factors to be present in this case, to varying degrees.

5.5.15. In discussion with Adult B, he spoke about his childhood. He referred to his parents splitting up when he was around two or three years old, feeling isolated and not fitting in anywhere, hanging around with the wrong groups and getting into trouble. He spoke about his nan and grandfather being a stabilising influence in his life, and being very upset when his nan died. He spoke about his grandfather giving him money to do odd jobs around the house or garden. Mr C clearly played a significant role in supporting and guiding his grandson. During the interview, Adult B conveyed a sense of having a difficult childhood and that this really impacted on his life choices and pathways taken. He went on to talk about and became upset when talking about not being able to see his children (prior to Mr C's death and entering prison) and that he found this very difficult. This, he felt, triggered to a worsening in his emotional health and his alcohol/drug use to increase.

5.5.16. In summary, the quality and effectiveness of agency responses to Adult B mental health (including self-harming) or alcohol misuse difficulties was variable. Two main issues that emerge are firstly, the importance of timely information sharing across relevant agencies in order to allow effective risk assessment, and secondly the challenge for agencies finding ways to engage those who are experiencing mental health difficulties or misuse alcohol, consistently and creatively; the very individuals' that find it difficult to consistently attend appointments and seek support may be the people that need the greatest support. Agencies have identified aspects of their service where improvements can be made however there is no direct correlation between the improvement activity identified and the interactions between Adult B and Mr C, and the circumstances of his death.

5.6. To examine whether Covid-19 restrictions had an impact on circumstances and events.

5.6.1. No specific issues relating to Covid-19 have been identified by any agency that came into contact with either Mr C or Adult B. However, it is not unreasonable to conclude that the impact of increased pressures placed on all services during times of lockdown restrictions may have added to the overall strain on services. Additionally, and potentially of greater note, is the strain placed on individuals and families during this time. In April 2021 lockdown restrictions were eased, and it is at this point we see from the chronology the emergence of Adult B's mental health difficulties,

[10] HALT Briefing Paper 2: Understanding Adult Family Domestic Homicide, HALT Research Team, undated, www.domestichomicide-halt.co.uk/

[11] Adult Family Homicide (AFH) is defined as the killing of one or more family members by another family member where both victim and perpetrator are aged 16 or over. For example, where an adult kills their parent or grandparent, HALT Briefing Paper 2. It may also be known as parricide – the killing of a parent or other close relative.

self-harming attempts and disclosures of domestic abuse by a former partner. Lockdown and restrictions would have been a time when Adult B was limited in his ability to earn money, and social contact would have been challenging. Contact by family members during lockdown' was challenging with different family members living across borders, and there being different rules to follow between England and Wales. Despite this, family members maintained contact, as best they could, with Mr C. Services offering appointments became more challenging and whilst there is no direct evidence of this being a factor in this case, the points made by Adult B, as set out in 5.5.3 about the reliability of his mobile phone or postal addresses should be recognised.

5.7. To examine whether there were any issues in relation to the nine protected characteristics under the Equality Act 2010 (age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, sexual orientation).

5.7.1. The characteristic of age has been reviewed. given Mr C age and associated declining health is a factor that requires special consideration as it can make someone more vulnerable to ongoing abuse it can certainly compromise the ability to manage when faced with an assault. In terms of the impact this may have upon the relationship between Mr C and his grandson the information from Mr C's network suggests that he was not a person who was systematically victimised and family and friends saw Mr C as a man of strength of character and independence as opposed to someone needing special protection. Additionally, ethnicity, culture, class, linguistics of respective family members, any special needs on the part of either victim or perpetrator were explored; again, there is no information to suggest that these are relevant to consider.

5.8. The impact of organisational change over the period covered by the review for any services which came into contact with relevant family members; whether this was a contributing factor in service delivery, and how this impacted on the service provided to any member of the family.

5.8.1. From the review of agency submissions, very little information has been provided to indicate organisational change affected service delivery to Mr C. The only possible exception to this is the point made above, in section 5.6, relating to the waiting times for an emergency ambulance to attend Mr C's home at the time of the assault; waiting times were reported to be five hours, and although not relevant to the learning about domestic abuse, it is important to recognise the impact and pressures on health services, not only as a result of the Covid-19 pandemic, but also with delays in hospital handover of patients, impacting on the release of ambulances to respond to 999 calls in the community. This pressure had been building in the months prior to this incident and continues to be felt.

5.8.2. On a positive note, the GP Practice for Adult B have identified that two Mental Health Nurses were employed at the Practice since September 2019. They are able to offer longer appointments and have access to a GP; resulting in improved access to the right sort of care plus continuity of support. Adult B saw one of these Nurses for consultation, referrals and follow up advice, and were able to gain a better understanding about Adult B's behaviours and history. Despite the Covid-19 restrictions, workload and stress were not having an impact on service delivery.

5.8.3. Midlands Partnership NHS Foundation Trust have highlighted good practice points which include their adherence to the National Institute of Clinical Excellence (NICE) guidelines when responding to Adult B, the responsiveness of the pathways used for their attempts to work with Adult B, risk management, and communication.

5.8.4. Shropshire Domestic Abuse Services have identified that there has been in impact on their service due to high referral rates and staff changes, which is likely to have affected the triage process and timeliness of response.

6. Lessons to be learnt

6.1.1. As a reminder, this review was commissioned to establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together.

6.1.2. By examining agency contact with Mr C, the victim, there is one lesson to be learnt which relates to a very historical matter, but which is relevant for practice today. As detailed in paragraph 4.11, Mr C was the victim of two vehicle related offences with Adult B being the perpetrator. Adult B was also bailed to reside at his grandfather's house and subject to restrictions; there is no indication that this was risk assessed as to any risk he may pose to his grandfather (the victim of the crimes). Family connectivity and bonds clearly ran strong, with Mr C stepping in to provide support and a home for his grandson who at the time was 17 years old. This is to be commended despite the fact that crimes had been committed. However, it also highlights the importance of all services working preventatively and effectively intervening earlier rather than later so as to reduce the likelihood of further problems; this is picked up further below. Beyond this, there are no direct lessons to be learnt for agencies that came into contact with M C.

6.1.3. However, learning has been captured by examining agency contact with Adult B. This relates to his relationships with intimate partners. Having collated and considered the information, no direct evidence has been presented to this review to indicate that, had different action been taken, it would have identified a dangerously dysfunctional relationship between Adult B and Mr C, or changed the pathway of events. There was no prior information to suggest that Mr C was at direct and explicit risk of harm from Adult B. The fact that Adult B posed a risk to other's cannot be taken to suggest he posed a risk to all. It does however show that his unpredictable, often volatile behaviours, were transferable to many of his relationships – whether that be intimate partners or family members - factors such as dysregulation, mental health issues and substance misuse can exacerbate abuse whilst not seeking to diminish the responsibility sits with Adult B.

6.1.4. The review therefore has highlighted four issues that do warrant further exploration at a strategic level by the Partnership, beyond this review.

- Firstly, the importance of earlier intervention with young people who have, or who develop, complex needs – particularly in relation to mental health, drug/alcohol misuse, and domestic abuse. Through earlier intervention and effective targeted support, there is a chance that it could reduce the likelihood of further problematic behaviours and being drawn into negative pathways during the transition into adulthood.

- Secondly, the need for all professionals to remain curious and alert to, signs of family dysfunction which may impact on health, safety and welfare; this does bring its own challenges, with already busy workloads, agency pressures and needing to address core business areas. However, cultural expectations and mindset is important to consider here. Standard practice now, for many professionals that enter family homes to conduct assessment or provide support, i.e., Health Visitors, Midwives, School Nurses, is to enquire (where possible and appropriate to do so) about family relationships and domestic abuse. Is this an expectation that could reasonably be extended to all professionals that enter a family home i.e., in this case Occupational Therapists for Mr C, but also where a patient might attend a clinic i.e., dietetics, cardiology?

- Thirdly, the need to examine how agencies configure their services so as to cater for those individuals that might be harder to reach and harder to sustain a professional relationship with. In many respects, these may be the very individuals that are likely to be in the greatest need, and who may, by not receiving support, represent the greatest risk either to themselves or others. Adult B is a good example of this – a complex constellation of needs built on by the cumulative impact of adversity and trauma, resulting in contact with a large number of agencies that provided support and intervention i.e., mental health, drug/alcohol and recovery programmes. Largely, these agencies were not successful at either engaging him to undertake a programme of support, or sustain the support offered. The emphasis then became one of him not maintaining contact, resulting in case closure. Invariably, the agency left dealing with Adult B, became the Police having to react to the risk he posed and deal with matters from a criminal justice angle.

- And finally, examining how agencies gain a sufficient understanding about how best to work with adults that pose a risk, and who have already experienced trauma. In Adult B's case, the restrictions placed around him not seeing his children was described by him as a trigger exacerbating his emotional and mental health, his anger, and his alcohol/substance misuse. Whilst the decision to limit, or prevent him having access to them for safety reasons may have been entirely right and proper for the children's safety (and mother), there may be something to consider about how he was informed about the decision making and how this was then followed through. Maintaining a dialogue with the traumatised person, knowing that additional significant decisions are likely to provoke a stress reaction, may be important in order to better manage triggers that are likely to result in risky behaviours.

6.1.5. As noted above, there is also learning identified by a number of agencies in respect of their contact with Adult B, in respect of his previous intimate relationships. These include:

6.1.6. West Mercia Police:

Considering previous relationship history for Adult B (not Mr C) lessons learned have included:

- Domestic Violence Protection Notices – There appear to have been missed opportunities to look at DVPN as a way to safeguard the victim to give them that breathing space from the suspect. (DVPN training has been completed to all frontline staff at the start of 2022, under pinned by a digital package later this year)
- Domestic Violence Disclosure Scheme (Clare's Law) – Due to history of Domestic Violence relating to Adult B there were opportunities to inform his partner under the "Right to Know". (Podcast is just being finalised for all staff to view around Sarah's and Clare's Law and will be rolled out in the next few weeks)
- Consideration of additional offences i.e., stalking and Harassment – Operation Reset training is being rolled out to all frontline staff around improving investigations through 2022.
- Risk Management Plans – there does appear to be an opportunity for RMP's to have been created earlier; this would allow for information to be recorded in one place and managed by local safer neighbourhood officers.
- DASH gradings- recognising High risk escalation triggers which mean a DASH should be recognised as high. i.e., such incidents involving strangulation.
- Contextualising risk from all domestic abuse histories relating to the perpetrator – West Mercia Police are in the process of rolling out Continuing Professional Development training to all frontline staff through 2022 around Contextualising safeguarding and Domestic Abuse.

6.1.7. West Mercia Police have also identified areas of good practice; these are important to acknowledge, as lessons can be learnt from positive practice as well as areas where there are opportunities for improvement. During the majority of reported incidents reported to the police, these have been dealt with in line with West Mercia's policies in relation to the following;

- Deployment by the Operational Communications Centre.
- Crime recording in line with Home Office Crime recording standards.
- Risk Management Grading.
- Referrals to partner agencies around the whole family.
- Listening to the voice of the community.

6.1.8. Adult social care

- If Adult Mental Health Services receive an Approved Mental Health Professional report with an action plan this could be checked that all actions have been followed through before closing. This should be completed by the Mental Health Social Worker duty worker.

6.1.9. Shropshire Recovery Partnership

- Information needs to be shared with other professionals involved with a service user in a timely manner so that risk management and safety planning can be effective. In this case, information could have been shared sooner with GP in relation to Adult B's suicide attempts.
- When a service user makes a suicide attempt, they should be offered a face-to-face appointment/assessment in order to conduct the best possible assessment and be offered the right support. In this case, due to Covid-19, Adult B was not seen face-to-face because the service office was closed – no alternative option was considered.
- Professional curiosity is important when assessing risk. In this case, it has been reported that there was a lack of professional curiosity and no exploration that all of his self-harming, dysregulated behaviour and suicidal ideation was as a result of him being intoxicated.

6.1.10. Shropshire Recovery Partnership have identified two aspects of good practice; namely the involvement of Adult B's mother in his care i.e., providing information and being connected in his care planning was considered helpful, and all agencies, including the GP were informed that Adult B had not maintained contact with the service, despite further appointments being offered to try to re-engage him into treatment.

6.1.11. Shropshire Domestic Abuse services

- Risk assessments need to be completed in a timely manner following an incident. In this case, a DASH risk assessment was not completed at the time of triage – had it been completed, it would have allowed a clearer picture of previous incidents involved Adult B.
- Responding to service users' needs to be timely following receipt of a referral for support services. In this case, nearly three weeks had passed between the receipt of the referral by Adult Social Care and first contact.

6.1.12. Adult B's GP

- It is important that all practitioners at the Practice are aware of unpredictable behaviour in patients with mental illness and alcohol and substance misuse. The use of coding/flagging on databases will help receptionists through to clinicians be aware of these particular patient's increased needs.
- The importance of recognising the effects that alcohol abuse has on the wider family.

6.1.13. Children's Social Care

- To ensure that historical domestic abuse is explored within multi-agency strategy meetings
- Ensure that perpetrators of violence are spoken to as part of the process and where this causes further risks of harm to the family, this should be recorded.

6.1.14. Midlands Partnership NHS Foundation Trust

During the contacts with Adult B between 2018 and 2021 some learning was identified; however, it has been confirmed with the relevant Team / Pathway Leads that practice has since been changed in the Trust. Nonetheless, the learning is:

- IAPT: Waiting times exceed national / contracted wait times: Current actions (2022) being taken to mitigate against additional waiting times include an accepted business case and service specification in preparation for a proportion of the current waiting list going out for tender for treatment. Also, currently in collaboration with the Clinical Commissioning Group and MPFT the cohort of clients waiting for treatment are being audited to identify service users whose complexities of psychological problems do not come within the service specification, identified for an IAPT service. The psychological complexities are such that, in most cases,

require a lengthier course of treatment than service users who present with mild to moderate measures of anxiety and depression. The impact of which includes longer waiting times for service users to start their course of treatment. Complexities also can be accompanied with risk to self and for these service users' therapists can spend time reviewing patient's welfare and risk, which reduces their capacity to start new episodes of treatment, which also impacts on waiting times.

- IAPT: Service user information / communication: No evidence that the IAPT discharge letter was copied to Adult B in 2018. The IAPT discharge process has been updated since 2018 and now includes: completing discharge IAPTUS data and writing to the GP, and / or other referrer and service user with details of the service user's engagement with the service, outcomes and details of risk. The service user's standard letter is derived from a template to assure this information is included.

- Access Team: Adult B had previously been assessed by the Crisis Resolution & Home Treatment (CRHT) service on behalf of the Access team and it was documented that no further action was required by secondary mental health services; however, Adult B's Access referral had remained open. This did not lead to any care or service delivery problems. The Access Team Lead have confirmed that supporting staff were / are provided with a standard induction and are advised of Access standard operating procedures and where to locate these for future use/ reference. It is now standard practice that a review of the working day, including tasks being undertaken by relief staff is conducted by the Shift Coordinator to ensure all actions are aligned to the Pathway.

7. Conclusion

7.1. This Domestic Homicide Review has examined the contact and involvement with an 80-year-old man, that died as a result of injuries sustained following an assault by his grandson. The grandson pleaded guilty and was convicted of manslaughter. The review has benefitted from reports from a number of agencies that had contact with the victim but also the perpetrator; the contributions of a family member has also been helpful, as has the assistance of one of Mr C's long-standing friends.

7.2. The review has found that there were concerns about the quality of the relationship between the victim and perpetrator, but these never reached a level that compelled anyone to seek professional help or advice. The victim had significant health needs, but these were managed effectively and without issue. The perpetrator had mental health and substance misuse difficulties, and these were never managed effectively; whilst these difficulties contributed to the quality of his relationships with female partners and his family they cannot be viewed as justifying his abusive behaviours. In addition to this, the perpetrator experienced adversity as a child which are likely to have impacted on life chances and relationships.

7.3. The review has captured a number of learning points for agencies in respect of agencies that worked with the perpetrator; these are unconnected to the circumstances of the victim's death. The review concludes by highlighting recommendations that each agency has identified, as well as recommendations for the Partnership.

8. Recommendations

8.1. As a result of this review those agencies that have contributed due to their involvement with the victim have identified recommendations and actions for themselves, many of which have been completed, but will need ongoing monitoring about how well they have become embedded, and the impact. These include:

8.2. Shropshire Recovery Partnership (We are with You)

- Ensure all incidents/risks relating to a service user are communicated to their GP within 24 hours.
- Promote the use of professional curiosity across all staff.

8.3. Shropshire Domestic Abuse Services

- Implement a revised triage process which covers completing the Domestic Abuse, Stalking, Harassment and Honour based violence Assessment Tool (DASH), alongside completing a DASH on all linked perpetrators to the victim/survivor.

8.4. Adult B's GP

- Increase awareness about alcohol abuse on the wider family - encourage clinicians to keep their view wide when considering management and assessing risk.
- Highlight patients with combination of alcohol / drug abuse and poorly controlled mental health and look at flagging – adding a note or code to the electronic record – that highlights patients at higher levels of concern.

8.5. Children's Social Care

- Historic domestic abuse to be explored as part of all Strategy meetings.

8.6. In addition to the above single agency recommendations, the following recommendations are made for the Partnership:

1. The Partnership to examine the early help offer specifically considering educational and preventative interventions with young people who commit offences, and who have complex needs based on a) earlier childhood adversity, b) presenting mental health difficulties, c) presenting with substance misuse, d) are involved with multiple agencies.

2. The Partnership to raise awareness about the need to be professionally curious when working with service users and routinely enquire about family relationships and dynamics. This should be extended to all professional groups that have contact with service users. Leaders should seek assurance that efforts to increase front-line professional curiosity are having an impact.

3. The Partnership to promote awareness about Domestic Abuse Disclosure Schemes/Clare's Law through websites, publications and professional development events.

4. Undertake a review of whether relevant MARAC information is shared with GP Practices across the Partnership; seek to implement a robust process which remedies any gaps identified.

5. The Partnership to review how agencies approach communicate and support parents who have had children removed (or they are unable to see) to support them to manage triggers that could lead to deterioration in wellbeing and further negative responses or behaviour.

Shropshire

Safeguarding Community Partnership

Domestic Homicide Review

Executive summary

Mr C (who died in September 2021)

Independent Chair & report author: Kevin Ball

Date: June 2024

Final Version incorporating Home Office Quality Assurance Panel final feedback.

1. The review process

1.1. This summary outlines the process undertaken by the Shropshire Community Safety Partnership Domestic Homicide Review Panel in reviewing the death of Mr C, aged 80 years, who died in September 2021. Mr C tragically died in hospital as a result of injuries sustained from an altercation with his grandson two days earlier. A subsequent Police investigation and criminal trial took place in December 2021. His grandson, to be known as Adult B, pleaded guilty of manslaughter and was sentenced to three years in prison. Mr C has been described by one close member of his family as 'meaning the world to them and 'being very caring'. One long standing friend described him as being a 'lovely character, and the life and soul of a party' and being missed by all of his close friends. Family members who have contributed to this review have confirmed that they are happy for the term Mr C to be used.

1.2. This review was conducted under section 9 of the Domestic Violence, Crime & Victims Act 2004. The decision to conduct a review was agreed in January 2022, and review process has taken approximately seven months to complete, and has benefitted from a Review Panel that have maintained regular oversight of the process.

2. Contributors to the review

2.1. From an original list of 20 separate agencies and services initially contacted to find out if they had any contact or involvement with Mr C, it became apparent that 10 agencies/services should be asked to submit an Individual Management Report. This is set out below, in table 1. All of the authors of the IMRs are designated individuals within their organisations (usually senior managers) who had no direct involvement with any of the principle subjects in this DHR. Each IMR is quality assured by another senior manager prior to being sent to the Business Unit and the author.

Table 1: Agencies/services asked to submit an Individual Management Report
West Mercia Police
Midlands Partnership NHS Foundation Trust
Wrexham Maelor Hospital
Shropshire Domestic Abuse Service (Connexus)
West Midlands Ambulance service
Shropshire Recovery Partnership (We are with You)
Shropshire Council Children's Social Care
Shropshire Council Adult Social Care
GP Practices x 2 (Mr C's & Adult B's)

2.2. The review has also benefited from the contributions of some family members and one of Mr C's close friends, as well as Mr C's grandson's perspective being obtained.

3. The review panel members

3.1. A Review Panel was established, and comprised of the following agency representatives:

Table 2: Review Panel membership		
Name	**Agency**	**Role**
Kevin Ball	Independent	Independent Chair & author
Lisa Gardner	Shropshire Safeguarding Community Partnership, Business Unit	Development Officer
Paul Cooper	Integrated Care System	Head of Safeguarding Adults
Steve Cook	West Mercia Police	Detective Inspector
Natalie McFall	Shropshire Adult Social Care	Assistant Director
Sonya Miller	Shropshire Children's Social Care	Assistant Director
Becky Dale	Probation Service	Deputy Head of Service
Rabinder Dhami	Fire & Rescue Services	Prevention Manager
Duncan Kett	Midlands Partnership NHS Foundation Trust	Head of Safety & Risk Management

Wendy Bulman	Shropshire Domestic Abuse Service at the start of the review, and then Shropshire Council	Manager & Domestic Abuse Strategic Lead
Nicola Albutt	West Midlands Ambulance Service	Safeguarding Manager
Alex Leeder	Drug & Alcohol Services	Drugs and Alcohol Development Officer

4. Author of the over-view report

4.1. In February 2022, the Chair of the Shropshire Safeguarding Community Partnership appointed Kevin Ball as the Independent Chair and report author for this Domestic Homicide Review. He is an experienced Chair and report author, notably of cases involving the harm or death of children, but also more recently Domestic Homicide Reviews. He has a background in social work, and over 30 years of experience working across children's services ranging from statutory social work and management (operational & strategic) to inspection, Government Adviser, NSPCC Consultant and independent consultant; having worked for a local authority, regulatory body, central Government and the NSPCC. Over his career, he has acquired a body of knowledge about domestic abuse through direct case work, case reviews and audit, and research and training, which supports his work as a Chair and reviewer of Domestic Homicide Reviews. During his career, he has worked in a multi-agency and partnership context and has a thorough understanding about the expectations, challenges and strengths of working across complex multi-agency systems in the field of public protection. In the last 10 years he has specifically focused on supporting statutory partnerships identify learning from critical or serious incidents and consider improvement action. He has contributed to the production of Quality Markers for Serious Case Reviews, developed by the Social Care Institute for Excellence & the NSPCC – which are directly transferable and applicable to the conduct of Domestic Homicide Reviews. He has completed the Home Office on-line training for Domestic Homicide Reviews and the Chair training course provided by Advocacy after Fatal Domestic Abuse (AAFDA). He has no association with any agencies involved and is not a member of the Shropshire Community Safety Partnership. There is no conflict of interest.

5. Terms of reference for the review

5.1. Those agencies providing Individual Management Reviews were asked to consider the following lines of enquiry as part of the terms of reference:

1. Each relevant agency/service's contact and involvement with relevant members of the family from January 2015 up to September 2021. January 2015 has been chosen as a point where it is understood that Adult B formed a relationship with a female who had two children. Importantly, any relevant information prior to this period should be included in any agency submissions.

2. To examine whether Mr C had any identified needs, and whether agencies and services were addressing those identified needs; if not, whether this made him more vulnerable.

3. To capture any concerns from family members, friends or the community about the quality of the relationship between Mr C and Adult B.

4. To capture any concerns from family members about access to services for Mr C in order to meet any identified needs, plus any insights into the quality and effectiveness of any services that he did access.

5. To explore the quality and effectiveness of agency/service response to Adult B regarding any reported incidents of domestic abuse with former, or current partners, and children living in the same household. In doing so, issues around information sharing, risk to others, and risk assessment/management should be examined. This should include consideration about the contributions of the Multi-Agency Risk Assessment Conference (MARAC)[1].

[1] MARAC - The Multi-Agency Risk Assessment Conference is a regular meeting where agencies discuss high risk domestic abuse cases, and develop a coordinated safety plan for the victim and his or her children. Agencies taking part may include Police, Independent Domestic Violence Advisors (IDVAs), Children's Social Services, Health Visitors and GPs, amongst others.

6. To explore the quality and effectiveness of agency/service response to Adult B regarding any mental health (including self-harming) or alcohol misuse difficulties he may have experienced. In doing so, issues around information sharing, risk to others, and risk assessment/management should be examined.

7. To examine whether Covid-19 restrictions had an impact on circumstances and events.

8. To examine whether there were any issues in relation to the nine protected characteristics under the Equality Act 2010 (age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, sexual orientation).

9. The impact of organisational change over the period covered by the review for any services which came into contact with relevant family members; whether this was a contributing factor in service delivery, and how this impacted on the service provided to any member of the family.

6. Summary chronology

6.1. For the purposes of this report, the following individuals are of interest:

- Mr C – the victim and subject of this review

- Adult B – the perpetrator and grandson to the victim

6.2. Following a report of fighting between Adult B and Mr C the Police attended Mr C's home in September 2021. On arrival it was clear to the Police that Mr C had sustained a head injury from being pushed to the floor, and which required medical attention. Mr C told Police that an argument had begun with Adult B about his Will and what money Adult B might be entitled to. Adult B had been drinking alcohol and left the property in Mr C's car. A 999 call was made by the Police in attendance, requesting medical assistance due to a head injury. Approximately 2 hours and 20 minutes later a paramedic from the West Midlands Ambulance Service control room contacted the patient, and a telephone assessment completed via one of Mr C's adult daughters who was also at the property; this resulted in an agreement that the patient (Mr C) would be taken to hospital by a family member to reduce the need to wait for an ambulance, and therefore the dispatch of an ambulance was not required. This did not happen and consequently Mr C did not receive any medical treatment for his injuries, as he expressed a view that he did not want to go to hospital.

6.3. An investigation was commenced and a DASH assessment[2] (Domestic Abuse, Stalking & Harassment) completed graded as 'medium risk'. Adult B was arrested the following day, interviewed and released on Police bail until the end of September pending further investigative enquiries into the assault.

6.4. A day later, the Welsh Ambulance Service was contacted via a 999 call from a third party, reporting that Mr C could not be woken. An ambulance was dispatched from the West Midlands Ambulance Service. Due to his unsteady and unresponsive condition, he was taken by ambulance to Wrexham Hospital. The following day, Mr C died. It was suspected that Mr C's death resulted from the injuries sustained two days earlier. Adult B pleaded guilty of manslaughter and was sentenced to three years in prison.

6.5. From review of submissions by agencies and services, Mr C had no, or very limited contact with the majority of those that contributed to the review. Mostly, Mr C was known to his GP who detailed that he had significant health problems of chronic obstructive pulmonary disease (COPD), ischaemic heat disease and heart valve problems. He had heart surgery in 2016 and was on anticoagulant medication because of his heart problems. He was in regular contact with the GP surgery.

6.6. Further information has been captured about Mr C from family, friends and neighbours, via Police witness statements. One family member described Mr C *'… as a helpful man, he had a heart of gold. He helped a lot of people in different ways over the years both inside and out of the family. Always ready to do a favour for anyone … Mr C's relationship with his grandson has been up and down big time. Adult B was always wanting money off Mr C. I expect*

[2] DASH assessment - The purpose of the DASH Risk Assessment is to give a consistent risk assessment tool for practitioners who work with adult victims of domestic abuse. It's used to help practitioners identify those who are at high risk of harm and whose cases should be referred to a MARAC meeting in order to manage their risk.

this was to buy beer & cigarettes. Adult B would always call Mr C asking if there was anything he could do to earn some money …'.

6.7. A long-standing friend of Mr Cs commented *'…I know Mr C's relationship with his daughters … was really good. Mr C's daughters would regularly visit to help out with chores. Mr C's relationship with his grandson, … was sometimes hot and sometimes cold … After learning of Mr C's death, I felt extremely sad and emotional … It made me angry as Mr C has done a lot for Adult B over the years …*'.

6.8. Prior to this point in time, there is relevant information which is of interest to this review, notably involving Adult B and his substantial contact with the Police, and by implication, other agencies. This is relevant to consider in the context of examining whether there is any learning for agencies and services.

6.9. Adult B has been known to the Police since he was 14 years of age, with him committing offences and being subject to criminal investigation and civil orders since 2003; offences included anti-social behaviour, allegations of theft, assault, criminal damage, and burglary. There were a number of multi-agency interventions from the Police, Education and Children's Services however the impact did not sufficiently alter Adult B's ability to regulate the behaviours which created concern. Two of these offences involved Mr C and related to vehicle crime; one of which resulted in Adult B being bailed to live with his grandfather. In 2010 Adult B was charged with assault and criminal damage against his mother and sibling. Adult B perpetrated abusive behaviour within his intimate relationships between 2010 and 2021, including hitting, biting, stalking and harassment, threats to kills, non-fatal strangulation, damage to property and was known to be highly controlling and coercive. Interventions included partners being referred to Multi Agency Risk Assessment Conferences (MARAC), being subject to Police risk management plans, being protected by a Restraining Order and having to flee to a Refuge, Strategy[3] meetings and Children's Services assessments. Adult B was imprisoned as a result of his abuse to an intimate partner. During this timeframe he was offered support from the Community Mental Health Team, his GP and a mental health Crisis Team – often following mental health crises that he was experiencing and which involved alcohol misuse resulting in unpredictable behaviour.

7. Key issues arising from the review

7.1. The following key issues arise from this review:

- No explicit or direct issues have arisen in connection to any agency or service that had contact with Mr C, in meeting his needs.
- Agencies and services prioritising the early identification and early intervention with young people who have multiple needs and may find themselves steered, albeit unwittingly, onto a negative pathway into older adolescence and early adulthood.
- The importance of all professionals keeping in mind, despite pressures and workloads, the whole family when working with service users, and exercising curiosity during their interactions so much so, that it allows the service user to feel empowered to share any concerns they may have about extended family members.
- When service users appear to be difficult to engage, or are inconsistent in their engagement with professionals, there may be a need to consider the reasons behind this, and adapt service provision and delivery in order to maximise service user participation.
- For agencies working with people who have experienced trauma and that pose a risk to others maintaining a dialogue with them and knowing that additional significant decisions are likely to provoke a stress reaction, may be important in order to better manage triggers that are likely to result in risky behaviours.

8. Conclusions

8.1. This Domestic Homicide Review has examined the contact and involvement with an 80-year-old man, that died as a result of injuries sustained following an argument with his grandson. The grandson pleaded guilty and was convicted

[3] Strategy meetings held under section 47, Children Act 1989 where a local authority have reasonable cause to suspect that a child who lives, or is found, in their area is suffering, or is likely to suffer, significant harm, the authority shall make, or cause to be made, such enquiries as they consider necessary to enable them to decide whether they should take any action to safeguard or promote the child's welfare.

of manslaughter. The review has benefitted from reports from a number of agencies that had contact with the victim but also the perpetrator; the contributions of family members has also been helpful, as have the assistance of one of Mr C's long-standing friends.

8.2. The review has found that there were concerns about the quality of the relationship between the victim and perpetrator but these never reached a level that compelled anyone to seek professional help or advice. The victim had significant health needs but these were managed effectively and without issue. The perpetrator had mental health and substance misuse difficulties and these were never managed effectively; whilst these difficulties contributed to the quality of his relationships with female partners and his family they cannot be viewed as justifying his abusive behaviours. In addition to this, the perpetrator experienced adversity as a child which are likely to have impacted on life chances and relationships.

8.3. The review has captured a number of learning points for agencies in respect of agencies that worked with the perpetrator; these are unconnected to the circumstances of the victim's death.

9. Lessons to be learned

9.1. By examining agency contact with Mr C, the victim, there is one lesson to be learnt which relates to a very historical matter, but which is relevant for practice today. Mr C was the victim of two vehicle related offences with Adult B being the perpetrator. Adult B was also bailed to reside at his grandfather's house and subject to restrictions; there is no indication that this was risk assessed as to any risk he may pose to his grandfather (the victim of the crimes). Family connectivity and bonds clearly ran strong, with Mr C stepping in to provide support and a home for his grandson who at the time was 17 years old. This is to be commended despite the fact that crimes had been committed. However, it also highlights the importance of all services working preventatively and effectively intervening earlier rather than later so as to reduce the likelihood of further problems; this is picked up further below. Beyond this, there are no direct lessons to be learnt for agencies that came into contact with M C.

9.2. However, learning has been captured by examining agency contact with Adult B. This relates to his relationships with intimate partners. Having collated and considered the information, no direct evidence has been presented to this review to indicate that, had different action been taken, it would have identified a dangerously dysfunctional relationship between Adult B and Mr C, or changed the pathway of events. There was no prior information to suggest that Mr C was at direct and explicit risk of harm from Adult B. The fact that Adult B posed a risk to other's cannot be taken to suggest he posed a risk to all. It does however show that his unpredictable, often volatile behaviours, were transferable to many of his relationships – whether that be intimate partners or family members - factors such as dysregulation, mental health issues and substance misuse can exacerbate abuse whilst not seeking to diminish the responsibility sits with Adult B.

9.3. The review therefore has highlighted four issues that do warrant further exploration at a strategic level by the Partnership, beyond this review.

- Firstly, the importance of earlier intervention with young people who have, or who develop, complex needs – particularly in relation to mental health, drug/alcohol misuse, and domestic abuse. Through earlier intervention and effective targeted support, there is a chance that it could reduce the likelihood of further problematic behaviours and being drawn into negative pathways during the transition into adulthood.

- Secondly, the need for all professionals to remain curious and alert to, signs of family dysfunction which may impact on health, safety and welfare; this does bring its own challenges, with already busy workloads, agency pressures and needing to address core business areas. However, cultural expectations and mindset is important to consider here. Standard practice now, for many professionals that enter family homes to conduct assessment or provide support, i.e., Health Visitors, Midwives, School Nurses, is to enquire (where possible and appropriate to do so) about family relationships and domestic abuse. Is this an expectation that could reasonably be extended to all

professionals that enter a family home i.e., in this case Occupational Therapists for Mr C, but also where a patient might attend a clinic i.e., dietetics, cardiology?

- Thirdly, the need to examine how agencies configure their services so as to cater for those individuals that might be harder to reach and harder to sustain a professional relationship with. In many respects, these may be the very individuals that are likely to be in the greatest need, and who may, by not receiving support, represent the greatest risk either to themselves or others. Adult B is a good example of this – a complex constellation of needs built on by the cumulative impact of adversity and trauma, resulting in contact with a large number of agencies that provided support and intervention i.e., mental health, drug/alcohol and recovery programmes. Largely, these agencies were not successful at either engaging him to undertake a programme of support, or sustain the support offered. The emphasis then became one of him not maintaining contact, resulting in case closure. Invariably, the agency left dealing with Adult B, became the Police having to react to the risk he posed and deal with matters from a criminal justice angle.

- And finally, examining how agencies gain a sufficient understanding about how best to work with adults that pose a risk, and who have already experienced trauma. In Adult B's case, the restrictions placed around him not seeing his children was described by him as a trigger exacerbating his emotional and mental health, his anger, and his alcohol/substance misuse. Whilst the decision to limit, or prevent him having access to them for safety reasons may have been entirely right and proper for the children's safety (and mother), there may be something to consider about how he was informed about the decision making and how this was then followed through. Maintaining a dialogue with the traumatised person, knowing that additional significant decisions are likely to provoke a stress reaction, may be important in order to better manage triggers that are likely to result in risky behaviours.

10. Recommendations

10.1. In addition to the above single agency recommendations, the following recommendations are made for the Partnership:

1. The Partnership to examine the early help offer specifically considering educational and preventative interventions with young people who commit offences, and who have complex needs based on a) earlier childhood adversity, b) presenting mental health difficulties, c) presenting with substance misuse, d) are involved with multiple agencies.

2. The Partnership to raise awareness about the need to be professionally curious when working with service users and routinely enquire about family relationships and dynamics. This should be extended to all professional groups that have contact with service users. Leaders should seek assurance that efforts to increase front-line professional curiosity are having an impact.

3. The Partnership to promote awareness about Domestic Abuse Disclosure Schemes/Clare's Law through websites, publications and professional development events.

4. Undertake a review of whether relevant MARAC information is shared with GP Practices across the Partnership; seek to implement a robust process which remedies any gaps identified.

5. The Partnership to review how agencies approach communicate and support parents who have had children removed (or they are unable to see) to support them to manage triggers that could lead to deterioration in wellbeing and further negative responses or behaviour.

Recommendation	Scope of recommendation	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target Date	Completion Date and Outcome
The Partnership to examine the early help offer specifically considering educational and preventative interventions with young people who commit offences, and who have complex needs	Local	An evaluation of the current Early Help offer. Redesign of current provision based on the evaluation findings.	Early Help	A new Service manager has been employed to the service a full evaluation of the structure and design of Early Help I Shropshire has taken place Collaboration with key stakeholders (including children and families) to be conducted and service redesign to be planned. Early Help and Support Team to attend the Domestic Abuse Triage, soon to become the new Partnership Integrated Triage (PIT Stop) meetings to ensure smooth allocation of incidences that do not meet the threshold for SW assessment	June 2023 November 2023 March 2024	There are two domestic abuse engagement leads sitting with the Early Help and Assessment Team. This model went live on 1st June 2024. The partnership also have "The Lighthouse Men" which is a programme to support fathers/male carers to improve parenting skills of boys coming to notice in years 6 & 7 who show increase an violent behaviour and aggression.
The Partnership to raise awareness about the need to be professionally curious when working with service users and routinely enquire about family relationships and dynamics. This should be extended to all professional groups that have contact with service users. Leaders should seek assurance that efforts to increase front-line professional curiosity are having an impact.	Local	A learning event on professional curiosity is to be delivered across the Partnership. Learning materials about professional curiosity should be readily available to professionals working with all individuals in Shropshire.	Business Unit	Learning Event Professional Curiosity (padlet.com) A learning event was produced and presented to 255 practitioners. It was also recorded and has been hosted on You Tube so it can be watched by those who could not attend. Learning Event Professional Curiosity (padlet.com) A Padlet of materials to compliment the event has been produced that will support anyone who wants to explore this topic further. It will also support supervisors with additional materials to use in supervisions. Anonymous feedback was sought by those who attended the event and this can be seen on the Padlet. Copies of these were shared with the Assurance groups for adults, children and community safety for discussion.	October 2023 Ongoing November 2023	October 2023 There will be further sessions on this topic in the future. November 2023

The Partnership to promote awareness about Domestic Abuse Disclosure Scheme/Clare's Law through websites, publications and professional development events.	Local	Hidden Men recording with Clare's Law presentation included to be loaded onto SSCP website and link sent to networks	Business Unit	This event was held June 2022 and the recording is available on You Tube. Unseen Men Learning Event Part 2 Recording - YouTube		There were 65 learners at the event and to date there have been a further 66 views of the recording on You Tube.
		Clare's Law disclosure booklet is on SSCP website	Business Unit	1018_02_ClaresLaw_Leaflet_VICTIMS_A5_ENG.indd (shropshiresafeguardingcommunitypartnership.co.uk)	Completed 31.10.22	This information has been placed onto the new SSCP website
		Clare's Law learning briefing to be developed and distributed across the Partnership	Business Unit	PowerPoint Presentation (shropshiresafeguardingcommunitypartnership.co.uk)	Completed 28.11.22	Disseminated across the Partnership and available on the SSCP website.
Undertake a review of whether relevant MARAC information is shared with GP Practices across the Partnership; seek to implement a robust process which remedies any gaps identified	Local	ICB primary care development team and Chief medical Officer to liaise with the MARAC chair to ensure that all MARAC minutes are shared with GP's	MARAC Chair and ICS	Review the current process and ensure that it is effective. If there are issues identified, then implement changes to remedy these. This process should be reviewed periodically to ensure its effectiveness.	Initially November 2023. Then ongoing	There is a system in place whereby an individual within the ICB receives MARAC information from the MARAC coordinators and they act as a conduit between MARAC and GP Practices. The Head of Children's Safeguarding in the ICB provides management oversight of these arrangements.

		MARAC minutes to be routinely shared with GPs of both Victim and Perpetrator	DALPB	This will be monitored through auditing and reported routinely to the Domestic Abuse Local Partnership Board	Ongoing	There is a review of the MARAC process being undertaken by Safelives and any actions will be monitored through the DALPB.
The Partnership to review how agencies approach communicating and supporting parents who have had children removed (or they are unable to see) to support them to manage triggers that could lead to deterioration in wellbeing and further negative responses or behaviour.	Local	Develop a resource for practitioners which signposts them to services available to parents who have had their children removed		Home - Project Lighthouse Midlands Partnership Foundation Trust – Lighthouse Project supports women who have had traumatic births. They also work with parents who have had children removed at birth. A learning briefing about this and other services for parents who have older children removed from their care to be shared with professionals across the Partnership.	March 2024	
The Partnership to develop a resource which supports people to consider the possibility of the abuse of older people.	Local/regional	A video to be produced regarding the hidden harm of older persons abuse		Hidden Harms - Domestic Abuse and Older Adults (Shropshire and Telford and Wrekin) (youtube.com) This video has been shared widely across the partnership and is hosted on the SSCP website. Also hosted is the Hourglass webinar from Safeguarding Adult week 2022 Stopping The Abuse of Older People | Hourglass Webinar (youtube.com)	November 2023	As of 01.07.24 there had been 285 views of the resource on You Tube. As of 01.07.24 there had been 254 views of this resource on You Tube.

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Lisa Gardner
Development Officer
Shropshire Safeguarding Community Partnership
Shirehall
Shrewsbury
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29th May 2024

Dear Lisa,

Thank you for resubmitting the Domestic Homicide Review (DHR) report (Mr C) for Shropshire Community Safety Partnership (CSP) to the Home Office Quality Assurance (QA) Panel. The report was considered at the QA Panel meeting on 24th April 2024. I apologise for the delay in responding to you.

The QA Panel found the report was clear and concise with a detailed chronology. They welcomed the detailed background on the perpetrator, which is helpful to understanding the bigger picture of the homicide. There is engagement with Mr C's family; his daughter and friends have contributed and there are reflections from them throughout the report which provides an insight to him as a person.

The QA Panel felt that there are some aspects of the report which may benefit from further revision, but the Home Office is content that on completion of these changes, the DHR may be published.

Areas for final development:

- The page numbers on the contents page need revising to align with sections in the report.

- The title amended in the report 'Chronology' has not been changed in the contents page.

- The equality and diversity section has been added to, it identifies age as one of the protected characteristics but could have widened to include sex.

- There is still some language present which could be considered to excuse the perpetrator, including the addition of 'dysregulation'. Whilst the QA panel appreciate the CSP's point about understanding the perpetrator's experiences of ACEs, the abuse does still feel minimised at times, including the economic

abuse and that the perpetrator injured the victim following an argument about the victim's will.

- The dissemination list should include the Domestic Abuse Commissioner and the local PCC.

- The report requires a thorough proofread.

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,

Home Office DHR Quality Assurance Panel