DOMESTIC HOMICIDE REVIEW OVERVIEW REPORT

Report into the death of Adult A, December 2017

Report produced by Peter Stride

Independent Domestic Homicide Review Chair. Foundry Risk Management Consultancy

On behalf of Windsor and Maidenhead Community Safety Partnership (RBWM CSP)

Report completion date: 22nd December 2020

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FORWARD

The Royal Borough of Windsor and Maidenhead's Community Safety Partnership (RBWM CSP) would like to express their condolences to all those affected by the sad loss of Adult A. We sincerely hope the learning and recommendations gained from our enquiries and deliberations will help agencies to prevent similar incidents from happening again in the future.

As the Independent Chair of the Domestic Homicide Review (DHR) Panel, I would like to thank all agencies who contributed to the process in an open and transparent manner.

This review has demonstrated that more needs to be done to raise awareness and change attitudes towards domestic abuse and that it is crucial to offer appropriate and timely help and advice to victims, their families, and friends, and to professionals. I am confident the learning points and recommendations will provide a platform to help local agencies to implement measures designed to prevent what happened to Adult A from happening to others.

Following Adult A's death, there is emerging evidence of positive change at a local level, and we all must do our utmost to take immediate action both to protect the victim and to deal effectively with the perpetrator and I would urge everyone to take note and act on the findings of this review. Together we must take the threat and harm posed by domestic abuse seriously at a leadership, frontline and community level to help bring domestic abuse to an end.

1. PREFACE

1.1 INTRODUCTION

1.1.1 Domestic Homicide Reviews (DHRs) were established on a statutory basis under Section 9(3) of the Domestic Violence, Crime and Victims Act 2004 and came into force on 13 April 2011.

1.1.2 This Overview Report, (hereafter 'the review') examines agency responses and support given to Adult A and Adult B, both residents of the Royal Borough of Windsor and Maidenhead (RBWM) at the time of the homicide, for the 13 years prior to Adult A's homicide in December 2017. In addition to agency involvement, the review will also examine the past to identify any relevant background or trail of abuse before the homicide, whether support was accessed within the community or there were any barriers to accessing support. By taking a holistic approach, the review seeks to identify appropriate solutions to make the future safer. The key purpose for undertaking DHRs is to enable lessons to be learned from homicides where a person is killed as a result of domestic violence and abuse. For these lessons to be learned as widely and thoroughly as possible, professionals need to be able to understand fully what happened in each homicide, and most importantly, what changes are needed in order to reduce the risk of such tragedies happening in the future.

1.1.3 This review process does not take the place of the criminal or coroner's courts nor does it take the form of a disciplinary process.

1.1.4 On a date in late December 2017 a male was seen by a member of the public walking and wearing blood-stained clothing. Following a phone call to police, officers stopped the male who was carrying a holdall which the officers searched to identify his name and home address.

1.1.5 Police officers took him to the family address where they discovered a female lying on the floor, in the lounge. She had significant head injuries and it was quickly discovered that she was dead.

1.1.6 The male was arrested on suspicion of murder and detained under the Mental Health Act 1983. In February 2019 the perpetrator was charged with murder. He was deemed unfit to enter a plea and in September 2019, following a 'Trial of Fact'[1], a jury found that Adult B had committed the act of killing his mother. The judge sentenced him to a hospital detention order with restrictions.

1.1.7 This Domestic Homicide Review was commissioned by Windsor and Maidenhead Community Safety Partnership (CSP) on 1st August 2018 to consider the

[1] https://www.theguardian.com/uk-news/2015/jun/29/lord-janner-case-what-is-trial-of-the-facts

contact/involvement agencies had with the victim and the perpetrator for the 13 years prior to her death in December 2017.

1.2 TIMESCALES

1.2.1 On 30th January 2018, in accordance with the 'Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews'[2] (hereafter 'the statutory guidance'), Thames Valley Police notified the Royal Borough of Windsor and Maidenhead CSP (RBWM CSP) that an incident, which had taken place in the local area, was being investigated as a domestic homicide.

1.2.2 The CSP members considered the case and concluded that it met the criteria for a DHR as defined under Section 9(3) of the Domestic Violence, Crime and Victims Act 2004. The Home Office were notified of the decision in writing on 1st August 2018.

1.2.3 The CSP commissioned the review and Peter Stride was appointed as Independent Chair (hereafter 'the chair') and review author on 25th September 2018. The Safeguarding Adult Board (SAB) confirmed they would not conduct a separate Safeguarding Adult Review (SAR) and it was agreed to widen the Terms of Reference for the DHR to include safeguarding considerations.

1.2.4 The first Review Panel meeting was held on 29th October 2018.

1.2.5 The Review Panel met six times and the review was concluded by the Chair in December 2020. The completed report was passed to the CSP in January 2021 and subsequently sent to the Home Office Quality Assurance Panel.

1.2.6 The statutory guidance states that a review should be completed within six months of the initial decision to establish one. The timeframe for this review was considerably extended for a number of reasons:

- The first Review Panel meeting was not held until 29th October 2018 and subsequent meetings were held on the 14th January 2019, 6th June 2019, 4th September 2019, 19th August 2020 and 8th October 2020 to ensure agencies could attend and the questions and issues raised could be addressed.
- The judicial process was not completed until the end of September 2019 as there were issues over the perpetrators fitness to plead.
- Due to personal bereavement the chair was forced to take a period away from the review process.

[2] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/575273/DHR-Statutory-Guidance-161206.pdf

1.3 CONFIDENTIALITY

1.3.1 The findings of this report are confidential until the Overview Report has been approved for publication by the Home Office Quality Assurance Panel. Information is available only to participating professionals and their line managers for the duration of the review.

1.3.2 This review has been suitably anonymised in accordance with the statutory guidance. The specific date of death has been removed. The subject of pseudonyms was discussed with family members, and it was the consensus that referring to the victim as Adult A provided appropriate levels of anonymity.

Pseudonym	Relationship	Age at the time of the incident	Ethnicity
Adult A	Victim	58 years	White British
Adult B	Perpetrator (son of victim)	35 years	White British
Adult C	Perpetrator's brother (1)	41 years	White British
Adult D	Perpetrator's brother (2)	29 years	White British
Adult E	Husband of victim (estranged) and stepfather of perpetrator	57 years	White British
Adult F	Birth father of perpetrator	U/K	U/K

1.4 TERMS OF REFERENCE

1.4.1 The full Terms of Reference are included at Appendix 1. This review aims to identify the learning from the homicide and for action to be taken in response to that learning with a view to preventing homicide in the future and ensuring that individuals and families are better supported.

1.4.2 The Review Panel comprised of voluntary and statutory agencies working across the Royal Borough of Windsor and Maidenhead, as the victim and perpetrator were living in that area at the time of the homicide. Agencies were contacted as soon as possible after the review was established to inform them of its inception with a request for their participation and the need for them to secure their records.

1.4.3 As information was provided during the review, it was established that Adult A had previous contact with agencies in other parts of the country. These agencies were contacted for information and involved remotely where appropriate.

1.4.4 The Review Panel set out the following key lines of enquiry:

- Set out the facts of agency involvement with Adult A and Adult B

- Critically analyse the service agencies provided in line with the specific terms of reference
- Identify any recommendations for practice or policy in relation to their agency
- Consider issues of agency activity in other areas and review the impact in this specific case

1.4.5 At the first meeting, the Review Panel shared brief information obtained from a 'summary of engagement' exercise about agency contact with the individuals involved. At this early stage it was evident that there had been engagement with a variety of agencies that had focused mainly on Adult B's mental health and very little on domestic abuse or coercive control. Adult B had never directly contacted any CSP agency, but the complex nature of the relationships within the family unit led to engagement with a number of agencies. It was also realised that Adult B had spent periods of time outside the CSP area, in residential care and this needed to be considered by the Review Panel. As a result, the Review Panel agreed that it was important to understand as much of the family history as possible and therefore it was agreed that the review period would cover 13 years, prior to the date of Adult A's death. Where appropriate, information about the relationship outside of this time period is included to provide context.

1.5 METHODOLOGY

1.5.1 On 30th January 2018, Thames Valley Police informed RBWM CSP of a reported murder within their area that had taken place late December 2017. It was agreed that a Domestic Homicide Review should commence which the CSP informed the Home Office about on 1st August 2018. The chair was commissioned for this DHR on the 25th September 2018.

1.5.2 Throughout this report the term domestic abuse and domestic violence are used interchangeably and the report uses the cross-governmental definition of these terms as issued in March 2013. They are included here in order to assist the reader to understand that domestic abuse is not only physical but includes a wide range of abusive and controlling behaviour. The definition states that domestic abuse is:

"Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass, but is not limited to, the following types of abuse: psychological; physical; sexual; financial; and emotional.

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

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

This definition, which is not a legal definition, includes so-called 'honour' based violence, female genital mutilation (FGM) and forced marriage, and is clear that victims are not confined to one gender or ethnic group.

1.5.3 The review has followed the statutory DHR guidance (2016). Upon notification of the homicide, agencies were invited to check and secure their records for details of any involvement with Adult A, Adult E or their (step) children. The approach adopted was to seek Chronologies and Individual Management Reviews (IMR's) from all organisations and agencies that had contact with the family. The outcome of this request is detailed in Section 1.7 of this review. A total of 10 agencies were contacted, with 2 reporting a nil return and 1 who had not retained any records. The remaining 7 agencies returned chronology reports and 6 of those included IMR's. The two agencies reporting a nil return were the Royal Borough of Windsor and Maidenhead's Children's Services who reported having no contact due the fact that Adult B was an adult when the family moved into the area, and the Dash (Domestic Abuse Stops Here) Charity. The one agency not completing an IMR was the South Central Ambulance Service (SCAS) who had three contacts with the family: one 7 years prior to the homicide when a call for assistance had been referred to the Out of Hours GP, who had managed the request; one 15 months prior to the homicide; the third contact was on the day of Adult A's death.

1.5.4 Documents Reviewed

As well as the IMR's and chronology documents, the chair and author have reviewed other documents during this review including:

- Royal Borough of Windsor and Maidenhead Joint Strategic Needs Assessment May 2019.
- Royal Borough of Windsor and Maidenhead Community Safety Partnership Domestic Abuse Strategy 2017 – 2020.
- Royal Borough of Windsor and Maidenhead Joint Autism Strategy 2017 – 2020.
- HM Government 'Ending Violence Against Women and Girls (VAWG) Strategy 2016-2020'.
- The Social Care Institute of Excellence (SCIE) guidance regarding the Mental Capacity Act 2005.
- The local Multi-Agency Risk Management Framework 2018.

1.6 INVOLVEMENT OF FAMILY, FRIENDS, WORK COLLEAGUES, NEIGHBOURS AND WIDER COMMUNITY

1.6.1 The chair made extensive efforts to identify a suitable family member to represent them in this review and consulted with the police Senior Investigator and Family Liaison Officers (FLOs). Due to no further extended family members, friends, neighbours, or other witnesses coming forward as part of the police investigation, only immediate family members were considered. A decision was taken to approach Adult D as Adult C and

Adult E were considered to be very emotional and upset during the police investigation and Adult F had become detached from the family and was living outside of the UK. Notwithstanding this the chair attempted to contact Adult's C, D & E via letter, telephone call and social media. These efforts proved to unsuccessful, (see 1.6.2 below).

1.6.2 The chair discussed pursuing the option of approaching Adult C, as a possible point of contact for the family, with the FLO's. It was apparent to the chair that Adult C was a vulnerable and a sensitive individual. The chair contacted Adult C and several telephone calls and text messages took place. It was clear that Adult C was extremely uncomfortable talking about the incident and remained resentful towards the perpetrator. His understanding of the review process was extremely limited, and he showed no interest in taking part.

1.6.3 A decision was made by the chair to pursue further engagement with the family at the conclusion of the review but prior to sign off. It was felt that this would allow a further period of grief and reflection to take place and for the police and FLO to better inform the chair how the family have settled down and whether contact and meetings with the family would be appropriate.

1.6.4 In October 2020 the chair was contacted by the FLO's who had continued to work with Adults C, D & E. They confirmed that the family felt they were ready to engage with the review and expressed their wishes to speak to the chair. The chair spoke to both Adult D and Adult E. These conversations were, with regards to Adult E, spread over several weeks and covered various subjects including his relationship with Adult A, his relationship with her three children (particularly the perpetrator), and his views on the services provided by the agencies involved with the family. Details of these conversations are detailed below, and a chronology of contacts with the three family members is recorded in Appendix 3. At the commencement of each interview the chair highlighted the availability of advocacy services and the content of the Home Office literature regarding support for families. These were also emailed to each party, as appropriate. The chair also discussed the subject of pseudonyms and explained that the report was using letters to represent everyone. It was the consensus of the three family members that this should remain the method used as it provided appropriate levels of anonymity. The chair felt that it was appropriate to respect this request.

1.6.5 Adult C

1.6.5.1 The chair has spoken to Adult C on two occasions, initially to explain the review process and to offer specialist advocacy support. The Terms of Reference for this review were provided verbally, and it was explained that he would have the opportunity to review and comment upon the report which would be given to him. Adult C asked for a chance to consider whether he wished to engage in this process and arrangements were made for a follow up phone call to discuss things. Subsequently Adult C confirmed that he did not want to discuss any details of his upbringing or any incidents which occurred during this review period however, he did tell the chair that he would like to see the Overview Report

and Executive Summary and it was agreed that due to the COVID-19 restrictions it would be appropriate for these reports to be emailed to him. This was done and arrangements made to call Adult C a week later. The chair has subsequently phoned and emailed Adult C on several occasions without any reply. Therefore, the chair must assume that Adult C does not wish to take any further part in this review.

1.6.6 Adult D

1.6.6.1 Adult D was spoken to twice, initially to explain the process and make the offer of specialist advocacy support. The Terms of References were provided verbally, and he was given the option to review the final draft of the Overview Report. Adult D explained that he did not wish to take any active part in this review or discuss any details of his upbringing or family life up to the point of the homicide, however he requested the opportunity to read the Overview Report and Executive Summary. This was agreed, however due to restriction of the COVID-19 pandemic, it would be done via email. Adult D agreed once he had received the reports the chair would provide a period of 7 days for him to read over the details and make any comments that he wished. The chair contacted Adult D who confirmed that the details of the report were fair and accurate, and he supported the recommendations and learning points. He also confirmed that he had nothing further to add to the report. The chair has offered his ongoing support and wishes to record his appreciation for the time taken by all the family in supporting this review process.

1.6.7 Adult E

1.6.7.1 Contact with Adult E took place during a period of lockdown due to the COVID-19 pandemic therefore the interview with him was completed over the telephone. Adult E has been offered help and support in contacting specialist advocacy agencies. The Terms of Reference of this review were provided verbally and discussed with Adult E. At the conclusion of the engagement with Adult E he was provided with an opportunity to review the Overview Report. Adult E explained that he had difficulties with both reading and writing so the chair arranged to have a video conference call with him in order that the report could be read over, and its contents discussed. It was at this point that Adult E decided to withdraw from the process. He expressed his appreciation for the work done by the panel and commented that he hoped the review would succeed in improving the lives of domestic abuse victims in the future. The chair has offered his ongoing support for Adult E but also understands that this was a difficult time and respects the decision Adult E has made.

1.6.7.2 It should be noted that whilst making arrangements to discuss the Overview Report the chair provided a note of caution that some of the content detailed actions by Adult E which may be distressing including incidents of his arrest, the period of separation from the Adult A and issues with the adult children. Adult E accepted this and commented that he could not change the past. The chair is extremely grateful to Adult E for taking this stance.

1.6.8 Chair interview with Adult E

1.6.8.1 The chair asked Adult E about how he and Adult A met, the nature of the relationship that he had with her and three children (Adult B, Adult C and Adult D).

1.6.8.2 As he mentioned in his interview with the police, Adult E met Adult A in 2006 through a lonely-hearts advert and within a few months had moved into the family home along with Adults B, C and D. The couple were married within a year of meeting. Adult E commented that when he moved in it appeared the three children ruled the roost, often arguing and bickering, and although they were very welcoming, he found the behaviour of Adult B to be somewhat of an uphill struggle, for example, Adult B could often be jealous of the attention given to Adult E as he wanted the same from his mother.

1.6.8.3 After living in the house for a while Adult E became frustrated with how he perceived Adult C and D were behaving. This led to some arguments and eventually Adult A told Adult C to move out.

1.6.8.4 Adult E commented that at Adult B's trial, Social Services described the family as dysfunctional which he thought was incorrect and unfair as Adult A had been on her own with the perpetrator for almost 18 years without any support and felt that Social Services did little to help and whenever Adult A or Adult E sought assistance from them, they were never available nor returned messages that were left.

1.6.8.5 The relationship between Adult A and Adult E began to breakdown due to the stress within the family and it was decided to seek help in having Adult B moved to a residential care home (Sennen Lodge). They regularly visited and began to form the opinion that Adult B was not receiving suitable care. On one particular visit the interaction with staff was perceived as poor and Adult A and Adult E noticed bruises on Adult B's body. They immediately removed Adult B from the Lodge and took him home. Adult E believes that Adult B was being abused, along with other residents, and he understands that eventually the Lodge closed.

1.6.8.6 Adult E perceived Adult A's efforts to get help from Social Services as a 'battle' but eventually it was agreed that Social Services would try to get Adult B into a residential placement nearer to the family home. Adult E explained that, by now, Adult A was becoming frail and battling with her own medical conditions.

1.6.8.7 Adult E has discovered, since the homicide, that once he had returned home, Adult B had become more aggressive and less responsive towards Adult A which she had disclosed to Adult D but asked him not to tell Adult E.

1.6.8.8 Adult E feels that Social Services had 'washed their hands' of Adult A and she had told Adult E that "He (Adult B) is better off with us".

1.6.8.9 Adult E said that Adult A had dedicated her life to Adult B, and she would do "Anything and everything for him". Adult E feels that Social Services let Adult A down by not taking Adult B into care or providing more support.

1.6.8.10 The chair has been provided with a summary of the interviews with Adult B, Adult D and Adult E, by Thames Valley Police. The interviews with Adult D and Adult E are documented within this section in order to summarise the relationships within the family and to provide a voice to the family.

1.6.9 Police interview with Adult D

1.6.9.1 The following is a summary of the details provided by Adult D during his interview with police officers as part of the homicide investigation.

1.6.9.2 Adult B was diagnosed with moderate to severe learning disabilities and autism, from an early age. He had always required assistance in his day to day living and his mother was his full-time carer. Adult B had lived in care for a period of 4 years and returned to the family home in 2012 where he lived at home with Adult D and Adult A.

1.6.9.3 Adult D explained that although Adult B has autism and that it affected his mental development, he was able to communicate safely with other people and although he jumbled his words, he was able to answer simple questions. He further explained that Adult B was looked after by his mother whenever he was not in a residential care home and that he went to a care home on the south coast following a fight with Adult E in November 2008. Adult D said that Adult B was mistreated in the care home, and he returned to the family home in 2012.

1.6.9.4 Adult D described Adult B as having a bad temper and being physically strong. He said that when Adult B lost his temper he usually shouted and screamed, but that things would be resolved very quickly. Recent to the homicide, Adult B's temper had become worse, he had started to pick things up and throw them or hit things. Adult B self-harmed by biting and punching himself.

1.6.10 Police interview with Adult E

1.6.10.1 The following is a summary of the details provided by Adult E during his interview with police officers as part of the homicide investigation.

1.6.10.2 Adult E met Adult A through a lonely-hearts column in a newspaper, in 2006. He moved in with her a few months later. At this point all three of Adult A's sons lived at home, although Adult C left home not long after Adult E moved in. Adult A and Adult E married in the summer of 2007. Adult A had told him that Adult B had previously broken her collar bone, and, on another occasion, Adult B had hit her.

1.6.10.3 Adult E confirmed that due to his work he had little to do with the day to day care of Adult B although he did help with feeding and dressing him. Adult A and Adult D did the majority of the caring.

1.6.10.4 Adult E did say that Adult A and Adult C did not get on and that Adult C had not seen his mother for over 12 months. Adult E described Adult B's mental health needs and behaviour in a similar way to how Adult D had, and that Adult A had taken care of Adult B for most of his life. He said that Adult B could get angry, but other than the disclosures as noted in 1.6.10.2, never offered his mother any violence.

1.7 CONTRIBUTORS TO THE REVIEW

1.7.1 The following agencies contributed to the review process as shown below:

Agency	Nature of the contribution
Thames Valley Police (TVP)	IMR & Chronology
East Berkshire Clinical Commissioning Group (CCG) on behalf of Primary Care	IMR & Chronology
Adult Social Care (ASC), RBWM	IMR & Chronology
Children's Services, RBWM	Nil return
Berkshire Healthcare NHS Foundation Trust (BHFT)	IMR & Chronology
Radian Housing Association	IMR & Chronology
Frimley Health NHS Foundation Trust	IMR & Chronology
South Central Ambulance Service (SCAS)	Chronology
The Dash Charity	Nil return
Sennen Lodge	No records kept

1.8 THE REVIEW PANEL

1.8.1 As per the statutory guidance, the chair(s) and the Review Panel are named, including their respective roles and the agency which they represent.

1.8.2 The Review Panel consisted of the following members and met on five occasions as outlined in 1.2.6:

Name	Agency	Job Title
Peter Stride	Foundry Risk Management Consultancy	Independent Chair
Mark Wolski	Foundry Risk Management Consultancy	Co-Chair
Christopher	RBWM Community Safety Partnership	Community Protection Principal
David	RBWM Community Safety Partnership	Head of Communities, Enforcement and Partnerships
Sophie	RBWM	Domestic Abuse Coordinator
Deborah	RBWM	Safeguarding Boards Business Manager
Vernon	Adult Social Care, RBWM	Head of Adult Social Care
Julie	Adult Social Care, RBWM	Strategic Adult Safeguarding Coordinator
Lin	Children's Services, RBWM	Director of Children's Social Care
Jo	East Berkshire Clinical Commissioning Group (CCG)	Named Professional, Safeguarding, Children and Adults at Risk
Karolyn	Radian Housing Association	Housing Manager
Jane	Berkshire Healthcare NHS Foundation Trust	Head of Safeguarding
Stefan	Thames Valley Police	Detective Inspector, Domestic Abuse Investigation Unit
Claire	The Dash Charity	Advocacy and Outreach Services Manager
Antony	South Central Ambulance Service (SCAS)	Head of Safeguarding

1.8.3 Independence and Quality of the IMR's:

The IMR's were written by authors independent of line management of staff or service delivery to any individual subject of this review. The IMR's were comprehensive and allowed the Review Panel to analyse contact with the family and produce learning for this review. Where necessary, further questions have been circulated to agencies in order to seek clarity and understanding. Responses were accurate and prompt. All the IMR's made commentary about performance and reported that service provision and execution were appropriate. They demonstrated current policies and expectations with regards to

performance as well as areas of good practice and lessons learned following this incident, as well as recommendations which have informed this review.

1.8.4 The chair of the review wishes to thank all those who contributed their time, patience and cooperation to this review.

1.9 AUTHOR OF THE OVERVIEW REPORT

1.9.1 Peter Stride was appointed by the RBWM CSP as Independent Chair of the Review Panel and Author of this review. Peter is a retired Metropolitan Police Officer and has over 30 years of detective experience in the field of Domestic Abuse, Public Protection and Safeguarding in London. His experience includes specialist and generic investigative roles at New Scotland Yard and a number of London Boroughs.

1.9.2 Mark Wolski (Co-Chair) completed 30 years of exemplary service with the Metropolitan Police Service retiring at the rank of Superintendent. During his service he gained significant experience leading the response to Domestic Abuse, Public Protection and Safeguarding.

1.9.3 Both Chair and Vice-Chair have completed Home Office approved DHR training and attended subsequent DHR chair training provided by Advocacy After Fatal Domestic Abuse (AAFDA).

1.9.4 Neither Peter nor Mark have any connection with the RBWM CSP.

1.10 PARALLEL REVIEWS

1.10.1 Criminal trial:
The criminal trial concluded in September 2019. Adult B was convicted of the murder of Adult A and was sentenced to a Section 37 Hospital Detention Order with Section 41 restrictions.

1.10.2 Coroner:
The Coroner decided no investigation was required and therefore, no inquest was held. Following completion of the criminal investigation and trial, there were no reviews conducted contemporaneously that impacted upon this review.

1.10.3 Safeguarding Adult Review (SAR):
The Safeguarding Adult Board (SAB) agreed not to conduct a separate Safeguarding Adult Review (SAR) and it was agreed to widen the Terms of Reference for the DHR to include safeguarding considerations.

1.11 EQUALITY AND DIVERSITY

1.11.1 The Review Panel considered all the nine protected characteristics, as defined by the Equalities Act 2010, during this review:

- Age
- Disability
- Gender Reassignment
- Marriage and Civil Partnership
- Pregnancy and Maternity
- Race
- Religion and Belief
- Sex
- Sexual Orientation

1.11.2 At the first meeting of the Review Panel, members identified that the protected characteristic of Disability required specific consideration. This is because Adult B would reasonably have been considered disabled owing to his dependency on his mother and authorities.

1.11.3 The Human Rights Act 2010 defines disability as:
"A person has a disability if she or he has a physical or mental impairment which has a substantial and long-term adverse effect on that person's ability to carry out normal day-to-day activities"[3].

1.11.4 There is no indication that Adult A's murder or any other incident was aggravated by these characteristics and tragically it is not possible to know from Adult A's perspective how any of these issues affected her.

Disability

1.11.5 A summary of the GP's patient records states that Adult B was diagnosed with hyperactivity and autism in 1986. Autism and recurrent seizures were formally diagnosed in 2001. In 1990 Adult A had attempted to take her own life and been diagnosed with depression. In 1999 there was a further diagnosis of Adult A's emotional condition and 2006 a second incident of overdosing. Since registering at the GP surgery Adult A was never prescribed any medication for her mental health. In 2016 there was a call to the GP 'Out of Hours' service, by Adult C and Adult E raising concern that Adult A was having a mental breakdown. This was followed up with an assessment by her GP, grading her overall risk as low.

[3] The Equality's and Humans Rights Commission report (January 2019)
https://www.equalityhumanrights.com/en/equality-act/protected-characteristics#disability

1.11.6 This review considered the barriers faced by Adult A, not only regarding her own emotional status but also in accessing services in supporting, and treatment for, Adult B. The records reflect that she had access to the following as part of a general care plan:

- Annual health check via the GP surgery
- Psychiatric referrals
- Admission to a specialist mental health unit for people with learning difficulties
- Residential Care Homes
- Services of the Crisis Resolution and Home Treatment Team (CRHTT)
- Community Team for People with Learning Disabilities (CTPLD), a team within the local authority Adult Services, respite support and development

1.11.7 Following a report from Adult C that Adult A had previously been a patient in a psychiatric hospital due to the stress of taking care of Adult B, there were three attempts by the GP surgery to arrange a mental health care plan for her however the phone calls were not answered and the matter appears to have been closed.

1.11.8 Adult A was very active in the care of Adult B, regularly visiting residential care homes and being responsible for his welfare and safety whenever he was at home. There were occasions when she challenged the services being provided to Adult B and at times removed those services or minimised their impact due to her desire to be his primary carer.

1.11.9 A further consideration is that of the long-standing challenges of disability faced by Adult B and Adult A, with regards to whether their mental health needs could have been intersected and how this impacted upon Adult A's perception of support services. It is an important reminder that agencies should consider someone's unique needs and experiences when engaging with CSP agencies.

1.11.10 Whilst the chronology from 2009 references a diagnosis of cancer for Adult A, there was no further mention of this from any other source, nor any information reflected in the health notes to suggest any treatment so there has been no further exploration of this.

Age

1.11.11 Considering the protected characteristic of 'Age', the review has considered whether, as she grew older, Adult A was more vulnerable to domestic abuse. Research on the extent and consequences of domestic abuse against older people remains limited.

1.11.12 The Femicide Census (2009-18)[4] provides some insight into the contexts of homicides involving older women. Data shows that most of the women aged over 60 years old were killed by a male family member, i.e., either a spouse or a son/grandson.

[4] Femicide Census – Profiles of women killed by men

1.11.13 Whilst it is recognised that many cases of domestic abuse go unreported, data from the Office of National Statistics (ONS)[5] indicate that the proportion of 'violence against the person offences' identified as being domestic abuse related, recorded by the police for year ending March 2021 indicate that for females, the proportion of these offences was generally higher for those in the younger age groups. The highest proportion being age 30-34 years old age category (57%).

1.11.14 There is limited research from the UK into theories of parricide (the deliberate killing of one's own father and/or mother'). Prominent features in parricide cases have included mental health, substance use and caring relationships and responsibilities[6].

1.11.15 The evidence and information provided to this review shows no reason to suggest that Adult A was any more vulnerable to domestic abuse at the age of her death than she had been at any time during Adult B's life.

Sex

1.11.16 The characteristic of 'Sex' has been reviewed and discussed as to whether Adult A's gender was an issue resulting in her homicide. Parricide victim characteristics show that in most cases (59%) the victim was female and 82% of perpetrators were sons or grandsons. Even when the victim was a male (41%) most perpetrators were also male (90%)[7].

1.11.17 Further review of ONS statistics evidence that women constitute 75% of all domestic abuse victims and therefore this is always a characteristic to be considered during any DHR. However, in this case the motivation for Adult B's ultimate action appears his belief that Adult A did not like a female that he was interested in.

1.11.18 Whilst the chronology provides evidence of sexually inappropriate behaviour, the last of these incidents occurred 10 years prior to the homicide. During discussions at Review Panel meetings, it was recognised that safeguarding processes are now significantly different, and those incidents would be managed a great deal differently to how they were managed at the time.

1.11.19 There is nothing coming to the attention of this review, to suggest that Adult B had any anger or mistrust issues towards women.

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[5] www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/articles/domesticabusevictimcharacteristicsenglandandwales/yearendingmarch2021#age

[6] London Domestic Homicide Review (DHR) Case Analysis and Review of Local Authorities DHR Process, 2019, Standing Together

[7] Domestic Homicide of Older People (2010–15): A Comparative Analysis of Intimate-Partner Homicide and Parricide Cases in the UK | The British Journal of Social Work | Oxford Academic (oup.com)

1.12 DISSEMINATION

1.12.1 Following sign off from the Home Office Quality Assurance Panel, the RBWM CSP will ensure the documents are disseminated to the Domestic Abuse Commissioner, Office of the Police and Crime Commissioner (OPCC) for Thames Valley, the Chief Executive (or equivalent) for all partner agencies and services represented on the Review Panel, the Safeguarding Partnership, and the Thames Valley Domestic Abuse Coordinators Group.

1.12.2 Anonymised electronic copies of the Overview Report and Executive Summary will be published on the RBWM website and copies of the report and letter from the Home Office Quality Assurance Panel be provided to the family.

2. BACKGROUND INFORMATION (THE FACTS)

2.1 THE HOMICIDE

2.1.1 In December 2017 police received a call reporting a male walking in the street, covered in blood. Officers began a search and Adult B was located wandering the streets. His hands and clothes were covered in blood and he was carrying a bag full of clothes. Officers attempted to engage with Adult B, but he was incoherent and was identified through the items in his bag.

2.1.2 The police officers went to Adult B's home address and forced entry. Once inside they discovered Adult A in the lounge with significant head injuries.

2.1.3 Adult B was arrested on suspicion of murder and detained under the Mental Health Act 1983. Following an investigation by Thames Valley Police, Adult B was charged with murder in February 2019. Adult B's mental health was assessed, and it was deemed that he was unfit to enter a plea during subsequent judicial hearings. In September 2019, following a 'Trial of Fact' a jury found that Adult B had committed the act of killing his mother. The judge sentenced him to a hospital order with restrictions.

2.1.4 A post-mortem examination was carried out on 31st December 2017 by a Home Office Pathologist and it was established that the cause of death to Adult A was a blunt force trauma to the head. The inquest was permanently suspended following the outcome of the criminal trial.

2.2 BACKGROUND INFORMATION

2.2.1 At the time of her death Adult A was 58 years old and lived at home with two of her sons: Adult B, who was 35 years old and Adult D, who was 29 years of age. Adult B was described by family members as having moderate to severe learning difficulties and when living at home Adult A was his full-time carer. Neither Adult B nor Adult D had ever been married.

Adult A had a third son, Adult C who had also lived in the family home until a row with Adult A 12-months previously which had led to Adult C moving out.

2.2.2 Adult A had previously been married to Adult F and they had two sons (Adult B and Adult D) however, their relationship did not last, and he subsequently moved out of the country. Adult A also had an older third son, Adult C, whose father is not part of this review. In 2006 Adult A met Adult E through a lonely-hearts advert and they were married a year later in 2007. They stayed together until 2015 when Adult E left the family home however, stayed in touch, meeting twice a week, away from the family home.

2.2.3 Each of the siblings demonstrated high levels of emotion and anxiety, which has affected their lives in different ways. The family appears to have been affected by challenges within the home and the evidence provided by the IMR's gives a clear inference of a complex family environment which made day to day living difficult.

2.2.4 Adult B was diagnosed with learning disabilities and autism with seizures from an early age and required assistance with his day to day living. He has spent significant periods of his life in various care services however Adult A moved Adult B back home due to her concerns over his welfare or treatment.

3. COMBINED CHRONOLOGY

3.1 This section summarises information known to each agency that were identified as having had contact with Adult B and Adult A in the 13 years prior to the death. Feedback was also requested from services, including those who had no record of meeting or engaging with them either as a family or as individuals. The following agencies returned completed chronologies and Individual Management Reviews (IMRs):

- Thames Valley Police (TVP)
- East Berkshire Clinical Commissioning Group (CCG) on behalf of Primary Care
- Adult Social Care (ASC), RBWM
- Berkshire Healthcare NHS Foundation Trust (BHFT)
- Radian Housing Association
- Frimley Health NHS Foundation Trust
- South Central Ambulance Service (SCAS)

3.2 It is noted from the outset that whilst the Review Panel wanted to explore an extensive time period, records from various agencies were not necessarily available to the extent that would enable a comprehensive chronology to be completed.

3.3 2005

3.3.1 In 2005 the family were known, or came to the notice of, a number of agencies including the RBWM Community Team for People with Learning Difficulties (CTPLD), Thames Valley Police and Adult A attended her GP for unrelated medical matters.

3.3.2 Adult B was attending a local college and known to the CTPLD who assisted in placing him in a local Day Care Centre, in 2006 (see below).

3.3.3 Between July and September, an allegation was made by a member of the public that Adult B had performed an inappropriate sexual act at a local swimming pool. The matter was investigated by the college and no further action was taken. It appears that there was no contact made with the police and the case notes do not explore the reasons why any further.

3.3.4 Between September and November, Adult A was concerned that her eldest son, Adult C, was depressed and she sought help from the local authority, requesting the services of the Community Mental Health Team (CMHT). A referral was made but Adult A was unhappy at having to wait for an appointment and indicated that she wanted immediate support. The records for Adult C are no longer available and this entry is based on the information available from Adult B's file.

3.3.5 On 28th September, police were called to a verbal argument between Adult A and Adult C. Adult B and Adult D had their details recorded. Adult A reportedly said that Adult C had "mental health issues". Furthers detail are not available.

3.3.6 In mid-November, Adult C tried to force his way into the family home and in doing so left Adult A with a chest injury. Adult A informed the CTPLD that she was concerned about the effect that this would have on Adult B and Adult D. Adult A asked that Adult D be at home when she was at work as Adult B had no support. The CTPLD looked into the possibility of respite as an alternative to Adult B being supported at home and as a result Adult B began attending a local day care centre.

3.4 2006

3.4.1 In 2006 the family came to the notice of a number of agencies including with a local hospital, Thames Valley Police and RBWM Adult Social Care.

3.4.2 Between 18th and 19th June, Adult A had been admitted to hospital following an overdose. She said that she had not intended to end her life. Following treatment, she was referred to the CMHT and her GP for support. There were no further medical entries for Adult A in 2006.

3.4.3 In July, Adult B left college and began attending a local day care centre.

3.4.4 In August, there were reports to the police of threats being exchanged between Adult E and Adult C. On 26th August, Adult E reported to the police that his stepson, Adult C, was making threats through a third party. On 29th August, Adult C asked police to put on record that he had received a text from his mum saying that her new partner was going to beat him up. Police records document that there was no reported history of domestic abuse although on-going family problems. No further police action was recorded.

3.4.5 In September, Adult A contacted the CTPLD and informed them that, whilst out with Adult E, there was an allegation that Adult B was sexually inappropriate in front of a young family. Social Workers discussed the matter with Adult A, and it was agreed that a referral should be made for Adult B to have a psychological review. A review at the local day care centre indicated that 1:1 support was in place and should continue whenever Adult B was out in public, mitigating the risk of Adult B doing the same thing again.

3.4.6 On 17th October, police were called by Adult A, on behalf of Adult D, in respect of Adult C making persistent, unwanted phone calls. Adult C was arrested the following day, for harassment, however he claimed he was trying to resolve family difficulties and he was released with no formal action being taken. Within hours police were called by Adult E who claimed that Adult C had threatened to kill him if he saw him. Adult C was arrested and following CPS advice, he was not charged but given a first instance harassment warning. Adult B's details were not recorded within the crime report.

3.4.7 On 24th November, Adult B was assaulted by Adult E whilst at a local day centre that Adult B visited three times a week. On this occasion, when Adult E and Adult A came to collect him, Adult B would not turn off a computer when asked to and Adult E shouted at him and slapped/pushed him on the back. Adult B ran out of the room shouting, "Don't hit me". Adult E followed him, and an altercation ensued which resulted in Adult B having scratch marks to his neck, bleeding from his mouth and a cut lip. Witnesses described Adult E attacking Adult B by hitting him in the face, grabbing him around the neck and trying to strangle him. Adult E was arrested and said the injuries were caused whilst he tried to restrain Adult B.

3.4.8 In Adult E's police interview he said that he had moved into the family home in April that year. He felt that Adult B had taken exception to there being another man in the house and had become more aggressive in recent weeks. A domestic violence risk assessment was carried out and the risk to Adult B was graded as Medium. The care manager at the local day care centre commented that she had questioned Adult A's ability to protect Adult B if Adult E was allowed to return home. A Visually Recorded Interview (VRI) was carried out with Adult B. He found it very hard to concentrate and communicate what had happened. He did say "[Adult E] hit me" and "I was frightened".

3.4.9 Adult E was charged with Common Assault and Actual Bodily Harm. Adult A would not accept Adult E back into the family home immediately after this incident. He was remanded in custody initially, though later given court bail. Adult A supplied a statement to police detailing the assault and supporting the prosecution, however, she later told

police that the statement was not accurate and that she no longer wanted to support proceedings. Adult E later pleaded guilty to the lesser charge of Common Assault. A 12 months conditional discharge was imposed on him.

3.4.10 In late November – mid December it was reported to Adult Social Care (ASC) that Adult B had kicked Adult A in the back, during an incident which had occurred at the local day care centre late in November. Adult A informed ASC that she had visited hospital and that Adult B was responsible for her injury. By this time Adult B was no longer attending the local day care centre as Adult A had removed him. A risk assessment and risk management plan meeting was convened and concern was expressed for Adult A's ability to care for Adult B, due to her injury.

3.5 2007

3.5.1 In 2007 there was very little contact with agencies, only a local residential care home and CTPLD.

3.5.2 In January – April, Adult A met with the CTPLD and agreed for them to look for a suitable residential home for Adult B. Contact was made with a local residential home and the family agreed for an assessment to take place. The placement was eventually agreed, and Adult B moved in on 25th May and he stayed until February 2008 (See 3.6.3).

3.5.3 In mid-June, Adult A and Adult E visited Adult B at the residential home and argued with CTPLD staff over the care that was being provided. Staff asked Adult E to stay away from the home. The CTPLD suggested that it would be in Adult B's best interest if he were to move to a residential care home away from the local area.

3.6 2008

3.6.1 In 2008 there was very little contact with agencies. There was one contact with a local residential care home that Adult B was staying at, one with a local unit at a hospital that Adult B was staying at later in the year and one with Thames Valley Police.

3.6.2 On 17th January, Adult A reported, to the care home Adult B was staying at, that his father was threatening to have someone cut Adult B's throat. Care home records say the police were informed, but there is no corresponding police record.

3.6.3 In February, Adult B was voluntarily admitted into the learning disability ward at a hospital in Reading[8] . Following a short admission, a place was found for Adult B at a specialist Learning Disability Care Home on the south coast, who offered a higher level of staffing. The care home was a residential setting for people with Autistic Spectrum Disorders and

[8] This unit is a nine-bed short to medium term assessment and treatment unit for people, over the age of 18 with mental health needs, when learning disability is the primary diagnosis.

Learning Disabilities. Adult B moved there in May and remained a resident there until 1st November 2012.

3.7 2009

3.7.1 In 2009 there was again very little contact with agencies. Adult A had contact with a local hospital for medical reasons that do not relate to the review and there was one contact of a domestic nature relating to Adult A as below.

3.7.2 On 30th May, police were called to the home address following a report that Adult E had grabbed Adult A around the throat and pushed her over and argued with Adult D. Officers attended and arrested Adult E. However, Adult A then declined to make a statement telling police that no assault had taken place but there had been an isolated argument due to stress caused by debt and her very recent diagnosis of cancer. Adult E was released from custody without interview. Adult B was not living at the address at this time. The police records show that a referral was made for Adult E to the Community Mental Health Trust and Adult Social Care.

3.8 2010

3.8.1 In 2010 there was again very little contact with agencies. Adult A had contact with a local hospital for medical reasons that do not relate to the review, there were two contacts with the police of a domestic nature relating to Adult A and one entry in relation to Adult B's residency at the Learning Disability Care Home. These incidents are detailed in paragraphs 3.8.2 – 3.8.4 and not considered to be a case of abuse involving multiple perpetrators. During subsequent interviews with Adult E this matter was discussed, and they confirmed that this was a minor family disagreement that was quickly resolved and also that Adult B had never been violent towards Adult A.

3.8.2 In January, there was an incident when Adult B locked a female service user in his bedroom. Staff gained entry and found the female unharmed. The room was searched, and pictures of fully clothed children were discovered which appeared to have semen on them. When asked about this, Adult B damaged his PlayStation. A few days later, concerns were raised that Adult B had damaged plug sockets in his bedroom. Care Home Risk Assessment records were updated, and Adult B was subject to 3 monthly reviews. The home considered the use of an occupational therapist with experience in working with sex offenders, however there are no records that such a specialist was employed.

3.8.3 On 13th August, Adult A reported she had received unwanted threatening phone contact and social media messages from Adult C following a dispute about guests who had been invited to his wedding. Police spoke to Adult C and advised him to have no further contact with his mother.

3.8.4 On 26th October, Adult A reported a further incident of unwanted contact from Adult C via email. Police advised Adult A these were spam emails and not sent by Adult C. No further action was taken.

3.9 2011

3.9.1 In 2011 there was very little contact with agencies. There was one recorded relevant contact with the care home where Adult B lived and a call to Thames Valley Police that was linked to unwanted contact from Adult C.

3.9.2 In the summer of 2011, Adult F contacted the care home and attempted to arrange for Adult B to visit him in France. Adult A discovered this and expressed her unhappiness at not being informed of these details.

3.9.3 On 1st September, Adult A reported that Adult C had been making unwanted contact with her, and as part of that initial report to the call taker, she mentioned that Adult C had, in the past, threatened to shoot one of her other sons. No further details of these threats were disclosed, by Adult A. A DASH (Domestic Abuse, Stalking, Harassment and Honour Based Abuse) risk assessment was completed and graded as Standard risk between Adult A and Adult C. There is little information about the shooting reference being explored further and Thames Valley Police said they would issue a harassment warning to Adult C. However, before the letter was issued, Adult A called the police and retracted the complaint explaining that she was trying to rebuild the relationship.

3.9.4 Between December 2011 and August 2012, following the commencement of legal action by Adult A to limit Adult F's contact with Adult B, the Local Authority received a letter from Adult A's solicitor requesting that a Best Interest's Assessment be carried out in relation to Adult B and contact with Adult F. This assessment was commenced by the CTPLD. A second solicitor's letter was received requesting a further assessment of Adult B's placement at the south coast care home and its suitability as a venue for Adult B's care.

3.9.5 On 29th December, Adult A called Thames Valley Police and reported that Adult F had threatened to take Adult B to live with him in France. The police advised Adult A to contact Hampshire Police and social services, which she said she had.

3.10 2012

3.10.1 In 2012, records show there were three domestic incidents reported to the police and that the only other notable event was Adult A withdrawing Adult B from the Learning Disability Care Home.

3.10.2 In June, Adult A reported that she had been receiving silent phone calls and that she believed these were from Adult C. The risk was assessed as standard, advice was given and the matter closed. Adult B was not resident at the address at this point.

3.10.3 On 18th July, Adult E reported that Adult C had been banging on the door whilst drunk. An appointment was made for Adult A to be seen by the police and a harassment warning letter to be sent. Adult B was not resident at the address at this point.

3.10.4 On 20th August, Adult A reported that her husband's car tyres had been deflated. She believed it to be her son Adult C. As there were no witnesses this matter was closed without further investigation. Adult B was not resident at the address at this point.

3.10.5 On 1st September, Adult A removed Adult B from the south coast care home due to concerns raised by Adult A over his care. The Royal Borough of Windsor and Maidenhead resisted this action and began legal processes under the Mental Capacity Act 2005. A capacity assessment, concerning Adult B's ability to decide where he would best receive care, was completed and professionals involved in the assessment process agreed Adult B appeared to be calmer at home than at the care home and his levels of self-harming had reduced. Adult B confirmed that this was the case. Support workers were provided to give respite to the family. An agreement was reached between Adult A and the CTPLD for Adult B to remain at home. The CTPLD gave Adult A support with housing issues and Adult B was encouraged to take part in community events. Adult A's support of this was recorded as being inconsistent. Adult B was assessed by social workers and deemed capable of making these decisions, independently. The situation was subject to regular reviews and Adult A's ability to care for Adult B was not questioned. Subsequent attempts by the residential care home staff to carry out an assessment of Adult B were unsuccessful. The final contact with Adult A was when she requested additional money for Christmas and winter clothing.

3.11 2013

3.11.1 In 2013, records show there were two incidents reported to Thames Valley Police and that the only other notable event was Adult A's concern over Adult B's weight gain whilst living at the south coast care home.

3.11.2 On 16th April, Adult A contacted police twice to report unwanted and threatening messages to her son Adult D believed to be from Adult C. Adult A thought there was an injunction in force, but she was referring to the Harassment warning letter that had been issued in 2011. Police visited Adult D at his home address, and he said he did not feel threatened by the messages and saw them as some kind of joke. The investigation was recorded as "Nuisance Messages" and the case closed with the rationale that it was not proportionate to do subscriber checks on the phone number.

3.11.3 Within a week, on 22nd April, Adult A called police to report that her husband had received at least 30 calls and when he answered the phone the line was dead. She believed they were from her son, Adult C. She expressed concern that he would come to the house and upset her autistic son, Adult B. She stated that Adult C had assaulted her in the past and broken her ribs and that this was reported to Lincolnshire Police. She also stated that Adult C had beaten up his wife in the past. Despite police recordings that Adult A was concerned about her autistic adult son, Adult B's details were not recorded in the report and so were not searchable for future incidents. The incident was recorded as a "Non-crime Nuisance Message". No DASH Risk Identification Checklist was completed as police could not ascertain that this was a domestic incident without subscriber details.

Subsequent enquiries by the team investigating the Homicide found no record with Lincolnshire Police or corresponding health records.

3.11.4 Early in the year, Adult B was referred by his GP for a medication review to the Consultant Psychiatrist working for the CTPLD. This request had come from Adult A as Adult B had put on a considerable amount of weight since starting a course of medication at the south coast care home. Adult A described Adult B's behaviour as being erratic, often 'shouting and jumping around' since returning to the family home. There is no reference to whether Adult B had been seen by the GP or his consent sought for this referral.

3.11.5 On 6th September, an appointment was offered to Adult B, by the BHFT CTPLD (health component of this joint team), to meet their Consultant Psychiatrist. An appointment was made for 3rd October. Adult A declined the appointment telling the staff that Adult B was fine. The offer remained open for 3 months before being closed.

3.12 2014

3.12.1 In 2014, records show there were a number of incidents reported to Thames Valley Police and two relevant entries by RBWM Adult Social Care.

3.12.2 On 21st January, BHFT noted that a further appointment was offered to Adult B, for the 27th January to meet their Consultant Psychiatrist. The RIO[9] notes suggest that this appointment was also cancelled by Adult A. She explained that Adult B was more settled with his medication and would not require support. A letter was sent to Adult B and his GP confirming that this referral was closed and that no further appointments would be offered.

3.12.3 The notes do not show that any conversation took place with Adult B about this appointment or his wishes. There was no obvious exploration of the symptoms or how they had improved to enable an informed decision to be made as to whether this referral should have been closed. The clinical notes were written by administrative personnel and there is no evidence that this decision was overseen by a clinician; however subsequent changes in the record keeping policy have sought to improve this service (See Section 7 'Early Learning').

3.12.4 On 19th June, during a journey to a local Social Group, Adult B disclosed to support staff that Adult D had hit him, and that Adult A had shouted at him. He also told staff that there were problems at home and that he wanted to pack his things and leave. It is clear that the CTPLD investigated this report and that Adult A confirmed that there had been a family argument but did not reveal many details. There were no signs of any bruising on Adult B's arms.

[9] RIO is a future-proof electronic patient records (EPR) system for community, mental and child health providers. It helps improve outcomes by providing a holistic picture of patients in your care.

3.12.5 On 30th July, Adult B's social worker contacted Thames Valley Police and reported that he had witnessed an argument between Adult B and Adult E. He stated that Adult E was very aggressive and pointed in Adult B's face. Adult B was shaking with fear (it is not clear where this happened). Adult B refused to go home if Adult E was there and social workers were not happy to let Adult B go home with Adult E present. A police officer attended the home address and saw both Adult E and Adult A, though Adult B was away from the house. The officer reported that Adult A was evidently scared of Adult E. Adult A stated that Adult E had been frightening her for the last couple of months and had been aggressive towards her, as well as expressing concerns about Adult E's mental health. The locks were being changed whilst the officer was present so that Adult E could not get back into the property. A DOM5[10] was submitted in relation to the risk between Adult A and Adult E, but the risk assessment questions were unanswered as Adult A declined to assist the officers. An incident which began as concerns about Adult E's behaviour towards Adult B became more about Adult A and Adult E, with Adult B never being seen by police. Neither the DOM5 nor the Domestic Incident report recorded Adult B's details, meaning that no risk assessment or onward referral could be made, and that the incident was not searchable against Adult B's name.

3.12.6 Adult A called the police the next day when Adult E came to the home address. Police attended and facilitated Adult E collecting some belongings. A Sig Flag[11] marker was put on the address in case of future calls. A DOM5 was completed and recorded that Adult E had mental health needs including Schizophrenia. Adult B and Adult D were reportedly present, but their details were not recorded on the incident report. Adult B's details and the fact that he had autism were recorded under "Further Relevant Information" on the DOM5, but this was not transposed onto the subsequent report as an "involved" person, so again would not be searchable at a later date. Had the attending officers assessed Adult B as potentially being at risk or adversely affected by the incident his details should have been recorded. It is not known whether the officers made that assessment.

3.12.7 On 11th August, Adult A called police and expressed concerns that Adult E's car was parked outside her house and that the security light kept coming on. Officers went to the house and confirmed that the car was not Adult E's.

3.12.8 The next day Adult B's social worker called the police to raise concern that Adult E had previously made threats towards Adult A. A DOM5 risk assessment was completed and graded the risk as standard, as Adult E no longer lived at the address and did not have a key to the property. An arrangement was made for Adult B and Adult A to visit the police station 2 days later, in order to review the matter. At that meeting it was confirmed that no new incidents had occurred, however it was recorded that Adult B was scared of Adult

[10] Thames Valley Police initial risk assessment form, replacing the DASH in 2013.

[11] A warning or information marker linked to an address that alerts operators when a further call relating to that address is made.

E and that Adult E had made threats to him in the past. A Risk Management Occurrence (RMO)[12] was created, in relation to Adult B, due to his vulnerability.

3.12.9 On 19th August, Adult A called the police and told them that Adult E had threatened to kill her, and that he "is coming tonight". She was concerned for the safety of her sons as he had made threats to Adult B and Adult D in the past. Officers visited Adult A and examined the messages, confirming that they were more of a nuisance in nature and not threats to kill anyone. This incident was classified as "Harassment [First single incident] Non-Crime"[13]. The officers visited Adult E and issued him with a Harassment Warning letter. A police alarm was fitted to Adult A's address and another RMO created with regards to the domestic violence between Adult A and Adult E. The IMR author noted that the report did not record Adult B or Adult D as aggrieved parties. The previous RMO, relating to Adult B, was not updated and the IMR author comments, "This would have been appropriate, based on the nature of the reported concern; providing a more accessible record of risk".

3.12.10 On 30th August, Adult A reported receiving a text message from Adult E asking to see the dog and to 'sort things out'. Officers contacted Adult E and advised him not to make any further contact; they recorded their rationale not to arrest Adult E as being that the content of the texts did not constitute full harassment and agreed that all future contact would be through his solicitor. A further DOM5 risk assessment was completed with the risk graded as medium risk; however, the details of Adult B were not transferred to the formal police report.

3.12.11 On 23rd September, the Adult Social Care records reflect that a 'Planned Review' took place. Neither the IMR author nor the records accessed can provide any detail of this review.

3.13 2015

3.13.1 In 2015, records show there were a number of contacts with agencies including Thames Valley Police, RBWM Adult Social Care and a significant number of contacts recorded by Radian Housing related to housing maintenance, rent and in August an incident of reported Anti Social Behaviour (ASB).

3.13.2 Between 7th January and August, Radian Housing received three rent related messages including text messages and a letter regarding Adult A being in arrears. There were six maintenance entries on the chronology, three of which resulted in an engineer attending.

[12] An RMO is a record on Niche created in respect of a particular risk (e.g. Domestic Abuse) and then forms part of an on-going record to monitor and manage the risk at that situation. The record is available to be updated with further incident, actions etc.

[13] Harassment offences involve a 'course of conduct,' or repeated actions, which could be expected to cause distress or fear in any reasonable person. This will often include repeated attempts to impose unwanted contact or communication on someone.

3.13.3 On the 6th March, during a planned review by the CTPLD, Adult B mentioned previously living in a south coast care home but had now moved home to live with Adult A and Adult D. He commented that Adult E had now moved out, that things were much calmer and that he was happier. He said during the meeting "My mother says that I don't like the cold and so instead of going to the Farm, on a Tuesday, I spend the day with my mum". The effect of this was to reduce the package of care from 21 hours a week to 12-13 hours. It was further reported that Adult A had asked for Adult B to return to the farm in May and it was agreed that this could be accommodated. It was also agreed that this would allow for further days out during the warmer weather.

3.13.4 During the review meeting, Adult A had said that she wanted Adult B to go to a local college one day a week and Adult B had agreed to this; however this hadn't worked out as Adult B said he found the environment too challenging and that he didn't like it.

3.13.5 An arrangement had also been put in place for fortnightly Skype calls to Adult F. During July 2015, Adult A raised concerns to the CTPLD regarding Adult F and Adult B having conversations via Skype, stating that she did not approve. Adult A had asked that this arrangement was cancelled as it made Adult B's behaviour difficult afterwards. It is not clear from records whether the Skype calls were cancelled or not. The CTPLD continued to maintain contact, throughout this period, including Mental Health Assessments to identify whether Adult B had the capacity to make up his own mind about these decisions. The assessment confirmed that he did not.

3.13.6 On 3rd August, Adult A contacted Radian to make a complaint over the behaviour of her neighbour who had referred to Adult B as a 'paedo' as well as swearing and making rude gestures towards them. Adult A provided details of other incidents involving the same neighbour, including a previous incident where Adult C had been pushed. Adult A was advised to call 101 if any similar incidents happened in the future. Adult A's social worker said that she was going to report this to Radian Housing due to the stress it was causing Adult A. An Anti-Social Behaviour log was created to record details of the incident.

3.13.7 On 5th August this matter was followed up with a phone call between Adult A and Radian staff. Adult A confirmed that these problems had been going on for 5 years. She was asked if the matter had been reported to the police and Adult A confirmed that she had only called Radian. Mediation was proposed however this was declined by Adult A. She also referenced an incident which had occurred the previous week, when the same neighbour had insulted Adult C. The call was ended when Adult A became frustrated at the perceived lack of support from Radian.

3.13.8 On 11th August, the Radian Neighbourhood Officer (NO) contacted Adult A and agreed that they should meet along with Adult B's social worker. On 13th August, the NO spoke with both parties and explained that was no evidence of any tenancy breaches and no evidence to justify any enforcement action. The only available path was that of mediation however Adult A declined to engage, and it was explained that there was nothing further that Radian could do in that case. The NO informed Adult A that they were going to write

to the other party, and it was agreed that the case would be closed. This was done the following day.

3.13.9 On 2nd October, Adult A called police as her son Adult C was staying at her address and he was wanted by the police in Wales. She wanted him removed as she was concerned about her "highly autistic son". Police attended and arrested Adult C.

3.13.10 On 19th October, Adult A made contact with Radian Housing to complain that the abuse from the same neighbour had begun again. Adult A said that the stress was proving too much for her son who no longer went into the back garden and that she was fed up with being tormented by the abuse from this neighbour. She was advised not to talk to her neighbour.

3.13.11 On 21st December, Adult B's social worker reported to the police that there were problems between Adult A and her neighbours. These issues had been long standing and Adult A was concerned that Adult B had been affected. Police attended the address and interviewed both parties. No criminal allegations were made, and the matter was referred to Radian Housing association. The police officer recorded that the troubles appeared to stem from an incident in 2004 that resulted in an assault on Adult A from the father at the neighbour's address. Police were involved but no charges were made. The attending officer recorded an anti-social behaviour Matrix score of 18[14]. No Niche record[15] was made which would have been expected and would have provided a retrievable record of actions taken.

3.14 2016

3.14.1 In 2016, records show an escalation in contact with agencies including Radian Housing, Adult A's GP, BHFT and Thames Valley Police and Adult A. Adult A's engagement with Radian Housing was predominantly related to rent arrears.

3.14.2 In February 2016, Adult B was seen by others to be touching himself inappropriately whilst out in the community. No detail has been recorded as to the nature of this touching. It has been noted from ASC records that Adult B and a particular female service user were kept apart during these activities after Adult B's behaviour had been noticed by CTPLD staff.

3.14.3 In March, whilst out on a social activity, Adult B damaged the door of a local hotel, as he was upset. A variety of reasons were offered for this behaviour including a change of staff in the hotel and a refusal by the same female service user to 'High Five' him. It appears that he threatened to stab his social worker although he calmed down later. Adult B was removed from the premises however it appears that there was no onward referral or information sharing.

[14] Matrix is an Anti-Social Behaviour risk assessment tool. A score of 0-19 is Standard risk.

[15] The Niche RMS™ Police Records Management System is an incident-centric tool that manages information in relation to the core policing entities: people, locations, vehicles, organizations (businesses or other groups), incidents (or occurrences) and property/evidence.

3.14.4 Between 4th May and 3rd June, Radian Housing records summarise a number of contacts of Adult A and Adult B feeling vulnerable. Adult A made several attempts to have their garden gate fixed. She spoke to Radian staff and told them that there was previously an intruder in the garden. Adult A was given a date of 28th July for a repair to be completed, but she asked for this to be brought forward. She spoke to the NO and stated that she had a disabled, vulnerable son living in her house and that her other son worked at night. Adult A stated that she was on her own and panicked at night. She made 4 calls between 24th May and 2nd June and whilst there is no recorded outcome, this matter is not mentioned again within the chronology.

3.14.5 On 1st August, Adult A called her GP to say that she was worried about Adult C. The GP tried to phone back but got no reply.

3.14.6 On 23rd September, Adult A called the GP surgery and told them that she was upset over and worried about her other son, Adult C. The medical records do not show any further details about what the specific worries were.

3.14.7 On 24th September, there was a 111 call from Adult C stating that Adult A was having "mental health problems". A Paramedic from 111 called Adult C back and whilst talking to him, Adult E took over the phone call and said that Adult A was well, there was nothing to worry about and there were no new or worsening symptoms. This was a conflicting set of events when compared to what Adult C had said earlier in the call. The 111 Paramedic tried to call Adult A but did not get a response. The 111 Paramedic was told by Adult A's husband that he was going home to see her.

3.14.8 When the 111 call was completed, the decision reached was to contact a Primary Care service within 1 hour. Therefore, a message was sent electronically to the East Berkshire Out of Hours Service for them to call the patient within 1 hour. The Paramedic advised that if there is any fear of violence or concern about welfare then the police should be contacted.

3.14.9 Adult A was contacted by the East Berkshire Out of Hours Service and she reported that it was Adult C, not her, who was mentally ill.

3.14.10 On 25th September, as part of a local mental health triage service (Op. Fledge)[16] a mental health professional and police officer visited both Adult E and Adult A's addresses. Adult A would not allow them into the address, and they did not see Adult B. As a result, a

[16] The service operates with an experienced mental health worker [a B7 or & CPN] working alongside a TVP police officer, at times during the day/night when the police are more likely to apply Section 136's. The two would attend emergency crisis calls made by a police officer who would be at the point of considering the application of a S136, with the health worker carrying out a mental health crisis assessment. The mental health worker would look for alternatives to the S136 being applied, such as referral to a local mental health service, or "de-escalation" of the patients' crisis, whilst at the same time releasing the police officer who made the call to resume their usual policing duties.
The service will operate with one member of staff [Band 7 mental health worker] and a TVP police officer on duty between the hours of 17:00 to 03:00, four days per week (Thursday to Sunday), this historically being the peak time for S136 detentions in East Berkshire.

report was prepared, from which the IMR author quotes "It would appear that Adult A is having a mental breakdown which required a follow up [i.e. by mental health services]". This was referred to the NHS BHFT Crisis Resolution and Home Treatment Team (CRHTT), for further action.

3.14.11 Following a visit on 25th September, the CRHTT sent a report to the GP surgery confirming that they had seen Adult A and that she had not consented to a full psychiatric assessment. The CRHTT had assessed her overall risk and graded it as low, and she was discharged from their service. The surgery followed this up on the 27th September with the offer of an appointment to see her GP. Adult A declined to attend and told staff she was fine.

3.14.12 Summer – Autumn the CTPLD tried to set Adult B up on a dating website to help him start a relationship. Part of this exercise was to support Adult B in building healthy relationships with others and this included discussions about sexual relations. His social worker looked into Adult B attending another local day care centre however Adult A was reluctant to support this.

3.14.13 Late September, Adult A told Adult Social Care that Adult C was trying to get her sectioned as he felt she was stressed and needed some support. She stated that he would regularly come to the address and upset Adult B. Adult A reported that Adult C called the CRHTT team and they paid a visit to the address. The ASC team observed Adult A serving a meal and that she appeared stressed. When questioned about this, Adult A put it down to their unexpected arrival at an inconvenient time. An offer of support was offered and rejected. Adult A called Adult C's GP and discussed her concerns about him not taking his Schizophrenia medication. She suggested that he may need to be sectioned.

3.14.14 On 3rd October, Adult A called the police and said that Adult C was still contacting her despite being warned not to. It was noted that this was an ongoing matter and 'name calling' via social media. Officers blocked Adult C's phone number on Adult A's phone. There was no mention of Adult B in the report.

3.14.15 On 22nd October, Adult A phoned the police again. Officers attended and she alleged that Adult C had sent her a nasty letter. Both parties were spoken to and advised not to contact each other. Following completion of a DOM5, the risk was initially graded as medium, but downgraded to standard after supervision. Notes record that both Adult A and Adult C were being managed by the Neighbourhood Policing Team and that a safeguarding plan was in place for Adult A.

3.14.16 On 24th October, the CTPLD manager completed a Mental Capacity Assessment to consider Adult B's suitability to attend a local day care centre. The outcome of the assessment is unknown due to quality of record keeping at the time.

3.14.17 From November 2016 to Summer 2017, Adult A stopped Adult B from attending a local day care centre, confirming that he no longer wished to visit. Adult A also contacted ASC and requested a change of Social Worker.

3.14.18 On 11th November and 23rd December, the GP surgery telephoned Adult A to request that she booked a mental health review. Adult A did not respond to either message.

3.15	**2017**

3.15.1 During 2017 there were a total of 37 contacts between Adult A and Radian Housing. Each of these contacts were reviewed by the chair. The calls and contacts related mainly to repairs to her home and discussions about housing benefits, including boiler servicing and repairs to electrical wiring and the replacement of minor household items due to wear and tear. There is nothing in the encounters to suggest any domestic abuse issues or matters of concern for this review.

3.16	**The day of the Homicide**

3.16.1 In December 2017 police received a call from a member of the public who had seen a male walking in the street apparently covered in blood. Officers visited the area and found Adult B. They established his address and attended the family home, where they discovered Adult A's body.

3.16.2 The Adult Social Care, Emergency Duty Team (EDT) was called by Thames Valley Police to the family home, following the death of Adult A. The police had established that Adult B had learning and communication difficulties and required an agency to act as an 'appropriate adult' during their investigation. The original call had been made whilst escorting Adult B back to the family home and a further call was made once he was at the police station. Adult B was sectioned under section 2 of the Mental Health Act 1983 and conveyed to a mental health facility.

4. OVERVIEW

This section summarises what information was known, to the agencies and professionals involved, about the victim, the perpetrator, and their families as well as other relevant facts or information about the victim and perpetrator.

4.1 ADULT SOCIAL CARE

4.1.1 Adult B was a man with a learning disability and autism and was known to the CTPLD since 2005. He was diagnosed with Autism at the age of 3 and had difficulties with both verbal and non-verbal communication, particularly eye-contact, expressions and gestures. Adult B had further challenges with expression and social skills and was assessed as requiring support in a number of areas including decision making, managing his own behaviour and daily activities.

4.1.2 In May 2007, Adult B moved from the family home into residential care however this placement lasted less than a year before he was voluntarily admitted into the learning

disability ward at a hospital in Reading. The unit is designed as a short-term assessment centre and after a short period of time Adult B was moved into a residential home on the south coast. He remained there for 4 years. However, due to concerns raised by the Adult A about the quality of care provided, Adult A moved Adult B back home to live with her and his brother. Regular support and reviews were carried out by the CTPLD between 2012 and 2017. There was initial concern about Adult B moving home however professionals soon agreed that he was doing much better living with his mother.

4.1.3 There were a number of reported incidents of Adult B presenting a risk to children and this was identified in 2005 when a psychological assessment recognised the potential risk and prepared an assessment for care providers to manage this. Over the review period there were several reported incidents of Adult B's inappropriate sexual behaviour towards children and there appear to have been managed mainly through internal processes. Analysis of the quality of record keeping is referenced in the analysis section, however it has been acknowledged, by the CTPLD, that during this period details were often not documented to reflect the work being done by those working with Adult B.

4.1.4 There were also several incidents involving Adult B and Adult E and it was reported that Adult B was frightened of his stepfather. These matters were regularly reported to other agencies and safeguarding measures introduced.

4.1.5 Adult B showed a particular attention to a female whilst attending a local social club. This was a club organised by the Berkshire Autistic Society. Adult B identified her as a potential girlfriend however these feelings were not reciprocated, and Adult B's attentions eventually led to the two of them attending the club on different days to avoid the unwanted contact that he presented.

4.2 BERKSHIRE HEALTHCARE NHS FOUNDATION TRUST (BHFT)

4.2.1 BHFT's initial engagement with Adult B and Adult A came about in 2012 when the dietician services were contacted for weight management advice as Adult B had put on a lot of weight during his residential care on the south coast.

4.2.2 In 2013 Adult B was referred for a medication review with the consultant psychiatrist at the CTPLD, however the appointment was rejected by Adult A as were further dates for review.

4.2.3 In 2016 there was a report from Adult C with regards to Adult A's emotional and mental wellbeing. As a consequence, the police and street triage worker visited Adult A's home and spoke to her. A view was formed that Adult A was having a mental breakdown and an appointment made for the CRHTT to return the following day and consider a Mental Health Act assessment (if required). A visit was made the following day and Adult A discussed her domestic situation and reassured the team that although she found caring for Adult B stressful, she was keen to scale back the support and take more responsibility herself. The agency records indicate that that there is no evidence of a referral under the

Mental Health Act assessment or continued engagement with the CRHTT as it was established that this was not required. A report was sent to Adult A's GP (4.3.1 below).

4.3 PRIMARY CARE

4.3.1 Adult A had been known to the GP Surgery for approximately 22 years and there had been 5 different contacts, during the review period, each regarding various mental health needs. In September 2016, Adult A spoke to her GP on the phone about the mental health of Adult C. Two days later, Adult E and Adult C contacted the surgery to report similar concerns over Adult A. This resulted in the home visits documented (4.2.3 above) by the CRHTT. As efforts to complete a mental health assessment were unsuccessful the surgery called Adult A several times and attempted to arrange a review. Adult A did not engage and told the GP that there was nothing wrong with her mental health.

4.3.2 Paragraph 1.11.5 provides details of the emotional and psychological challenges faced by Adult A throughout her life. During her time at the surgery, Adult A was never prescribed any medication for her mental health.

4.3.3 Adult B's GP records evidence that he was diagnosed with 'hyperactivity and autism' in 1986 and this was formally recorded in 2001, along with frequent seizures, which were well managed with medication. Adult B's outpatient appointments, to manage his epilepsy, were often not attended or were cancelled by Adult A.

4.3.4 The GP that Adult B was registered with locally does not have medical records between 2008 – 2012 as Adult B was in residential care on the south coast during this time. Adult B was regularly invited to attend an annual Learning Disability Health check; however Adult A declined these offers on Adult B's behalf. It was recorded that as Adult B did not have a complex medical history or long-term physical health conditions, the GP was not overly concerned at Adult B not attending these Health checks.

4.4 RADIAN HOUSING

4.4.1 Radian Housing had a total of 111 contacts with Adult A and other members of her family. There were no reported incidents of domestic abuse and contact was primarily with regards to general maintenance matters and various matters of rent payments and tenancy issues, however there were several incidents involving neighbour disputes, between August and October 2015.

4.4.2 Adult A and her neighbour fell out over an incident where the neighbour was allegedly abusive towards Adult B. The incident appears to have been historic but was the source of a number of complaints which resulted in the Radian NO proposing a process of mediation. Adult A confirmed that she was not interested in taking part and this was not pursued or explored any further by Radian.

4.4.3 There was a further report where Adult C was, allegedly physically abused by the same neighbour and the matter was reported to the police.

4.4.4 There was a meeting with Adult A and Adult B's social worker in August 2015 to discuss the impact that these incidents were having within the family unit. It appears that there were no records to suggest the allegations of anti-social behaviour were ever pursued or that Adult A was offered any additional support.

4.4.5 In October 2015, Adult A contacted Radian to complain of further anti-social behaviour from the same source. Adult A commented that this was too much for Adult B. An appointment was for booked for the NO and Adult B's social worker to meet the family; however, no record of this meeting has been recovered. A similar arrangement was proposed for December 2015 but there are also no notes of this meeting taking place either.

4.4.6 Adult A and the NO spoke twice on the phone in December 2015 and matters appeared to have calmed down as there were no subsequent reports of these types of incidents.

4.5 THAMES VALLEY POLICE (TVP)

4.5.1 During the reporting period there were approximately 24 relevant contacts between Thames Valley Police, Adult A and the family. The nature of the contacts varied in terms complainants and suspects although only 3 referred to Adult B and all were with regards to him as a victim or vulnerable person as listed below:

1. In November 2006 it was reported that Adult E had assaulted Adult B at the day care centre which he attended. Adult E was arrested and ultimately convicted of assault.
2. In July 2014 Adult B's social worker contacted the police to raise concern that they had seen Adult E shouting at Adult B and that Adult B was frightened of him. Police officers visited the family home and Adult E was escorted away. The following day Adult A called once more, to report that Adult E was banging on the door. Officers attended and were present when Adult E collected his belongings and left the area.
3. In August 2014 it was reported, by Adult A, that Adult E had made threats to harm both her and Adult B. The police investigation identified that no offences had been committed although safeguarding measures were put in place by the officers.

4.5.2 There were no incidents of Adult B calling the police and only one case when Adult B was spoken to by officers, prior to his arrest (incident 1 above).

4.5.3 The remaining contact between family members and the police breaks down as follows:

- 11 incidents where Adult A reported being the victim of either threats, malicious communications, threats, or anti-social behaviour, by other family members
- 2 cases of reports where Adult C was the victim of threats of violence by another family member

- 1 report of threats being made by Adult C towards Adult D
- 1 Report by Adult E regarding concerns over Adult A's mental health
- 1 report of Adult C making threats towards Adult E

4.5.4 There were other incidents where no suspect was ever identified and another matter whereby Adult C was served a summons after failing to appear at court, in Wales.

4.5.5 Other Arrests:
In May 2009 Adult E was arrested for assaulting Adult A however she decided not to support the allegation and Adult E was released without charge.

4.5.6 As can be seen there was a complex lifestyle at the family home and despite the fact that Adult B was living in residential care for long periods, he was present at a good many incidents to which police were called despite Adult A's effort to shield him.

4.6 OTHER REVIEW PANEL AGENCIES

4.6.1 Frimley Health NHS Foundation Trust

4.6.1.1 This agency was not involved with Adult B and their involvement with Adult A focused upon various other unrelated healthcare issues.

4.6.1.2 On 17th July 2006 Adult A was admitted to hospital following a drugs overdose of Carbamazepine and Co-codamol. On 19th Adult A received a psychological assessment and told the clinician that she had taken the overdose. She confirmed that it was not her intention to end her life. An onward referral was made to the psychiatric liaison team, the CMHT and her GP for support.

4.6.1.3 There were no other incidents or matters of interest.

4.6.2 South Central Ambulance Service (SCAS)

4.6.2.1 SCAS had two dealings with Adult A prior to the day of the homicide.

4.6.2.2 On 18th December 2010, Adult A called 999 to complain about a shortness of breath. The WestCall Out of Hours doctor was assigned, and an ambulance was not required.

4.6.2.3 On 24th September 2016, SCAS received a call from Adult C staying that Adult A had "mental health problems" and that they were worsening. Adult C stated that Adult A had started to become violent and would not let anyone into the family home. The call was then taken over by Adult E who stated that everything was fine and there were no concerns over Adult A's mental health. The call handler was not able to triage the call as there were conflicting statements. Adult A was not spoken to and the matter was passed to the Out of Hours GP for East Berkshire.

5. ANALYSIS AND LEARNING POINTS

5.1 DOMESTIC ABUSE/VIOLENCE

5.1.1 Adult A died as a result of a single, fatal act of domestic violence during an assault by Adult B. She suffered multiple impacts from a heavy blunt object.

5.1.2 Considering the government definition of domestic violence and abuse, which describes a pattern of incidents of controlling, coercive or threatening behaviour, there is information which indicates that Adult A was the victim of a wider pattern of domestic violence and abuse. Paragraph 3.11.3 records that Adult A suggested she had been assaulted by Adult C when they lived in Lincolnshire. On another occasion, Adult A reported to ASC that she had been kicked in the back, by Adult B (as per 3.4.10 above). The reporting of these incidents was historic and never formally recorded or investigated. When interviewed by the police following the murder, Adult D and Adult E were able to provide information suggesting that Adult B had a short temper but had never offered any violence towards his mother. However Adult E disclosed that Adult A had told him that Adult B had previously broken her collar bone, and, on another occasion, Adult B had hit her. Adult B had never reported any incidents of domestic violence nor had any similar allegations been formally made against him by Adult A. However, given the nature of the contact between Adult A, the other members of the family and the CSP agencies it is important to note that the absence of formal evidence is not the same as being able to say such violence or abuse did not occur.

5.1.3 There were no obvious indicators known to professionals that Adult B's actions or behaviour were going to escalate at this point. The combined chronology shows that there had been no contact with the family, for at least a year prior to the homicide with agencies.

5.1.4 This review aims to outline a picture of events as known to agencies and individuals involved with the family. Adult A had her own mental health challenges but did everything in her power to support Adult C, Adult D and Adult B. Adult A appears to have been a fairly independent person who chose to care for Adult B in her own way, often declining opportunities for help and support. As was noted in September 2016, when visited by the mental health team Adult A believed that, not only did she have all the support she needed, but that she wanted to reduce the levels of support.

5.1.5 However, there is a picture of a complex family environment including several incidents of threats and harassment towards Adult A and incidents of domestic abuse involving both Adult C and Adult E. It is noted that Adult B was never a protagonist and was a victim of assault by Adult E. This subject is discussed later in this section.

5.1.6 If Adult A did have wider concerns about experiencing any domestic violence and abuse from Adult B, she appears to have kept this to herself and this could have been for a number of reasons. Barriers to domestic abuse help seeking can include a number of

reasons including fear of more abuse, affection for the abuser, family loyalty, feelings of embarrassment or shame.

5.1.7 Adult B had Autism. He did not have keys to the family home or a mobile phone and appears to have had minimal independent involvement outside the controlled environment of the family home or various supervised activities, day centres and residential care. There are several reported incidents of his sexual interest in young girls, throughout the review period, including alleged incidents at a local swimming pool, canal pathway and residential care home on the south coast. During his time at a local social club he clearly took an interest in a female service user and made it known that he wanted her to be his girlfriend. The woman did not reciprocate Adult B's feelings and his persistent behaviour raised sufficient concern for changes to be made including ensuring that the two parties attended the club on separate days.

5.1.8 The woman had left the area over a year before Adult A's death, however when he was stopped on the night of the homicide it was thought that he intended to visit this service user and had written her a Christmas card. When interviewed after Adult A's death, Adult B told officers that the reason for him killing Adult A was because she didn't like this woman and that Adult A was bad. Adult D told officers that shortly before her death Adult A had told him that the Adult B needed to understand that the woman had moved away. In light of this information the Review Panel has drawn the conclusion that this was the likely motivation behind the homicide.

5.1.9 Adult B had been diagnosed with 'hyperactivity, with Autism' in 1986 and Autism was 'formally' recorded in 2001 along with recurrent seizures. In 1990 Adult A was diagnosed with depression and in 1996 she was further diagnosed with schizophrenia. Medical records confirm that she had never been prescribed any treatment or medication for her conditions. Adult B's mental health needs were certainly reflected in the sentencing at his trial where he was deemed unfit to enter a plea during subsequent judicial hearings and a Section 37/41 Mental Health Act 1983 Order[17] was granted. Matters relating to mental health and service responses are discussed later.

5.1.10 Recent research[18] into domestic homicide has explored the importance of "homicide triggers". When found alongside an offender's emotional or psychological state and the presence of acknowledged high risk factors, these triggers may indicate that homicide is a real threat. Among these triggers are: separation/ rejection; failing mental health and humiliation.

5.1.11 While the limited information in this case means it is difficult to be certain as to the presence of these markers, some appear to have been present. These include the prospect of 'separation/rejection'. There is more explicit information, provided by Adult E, about

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[17] www.rethink.org/advice-and-information/rights-restrictions/police-courts-and-prison/section-3741-of-the-mental-health-act/

[18] Monckton-Smith, J., Szymanska, K., and Haile, S. (2017) *Exploring the Relationship between Stalking and Homicide.* Available at http://eprints.glos.ac.uk/4553/1/NSAW%20Report%2004.17%20-%20finalsmall.pdf [Accessed 15th April 2018]

Adult B's behaviour beginning to deteriorate. He had started to get angrier and thrown things in the home. Because individuals with autism, particularly Autism Spectrum Disorders (ASD) are generally taught compliance from a very young age, they have difficulty picking up social cues and may also have intellectual disabilities.

5.1.12 There is a tendency when faced with such homicides to conceive of these as 'inexplicable' and 'out of the blue'. The description of a homicide in this way can obscure the facts of a case (particularly when looking at the circumstances retrospectively) which may include common factors such as mental health factors, Safeguarding alerts, Temporal Sequencing and Multi-Agency Risk Assessment (MARAC)[19] referral opportunities.

5.1.13 There is also the matter of Adult A's role as a carer. Throughout her life Adult A had been a dedicated and loving mother. She had received regular and differing agency support; however, she had always maintained an element of control in the service which Adult B received and was confident in removing or declining these services if she believed that they were not in his best interests[20]. There is a matter to discuss with regards to her role as a formally recognised legal carer. During his adult life Adult B was offered a number of medical assessments and virtually all were declined or ignored.

5.1.14 This review can find no record of Adult A ever completing a formal 'Carer's Assessment' and this will be discussed later in this section.

Learning Point 1

Parental Responsibility and Carers Assessment. Throughout the review it has been apparent that Adult A has acted in the role of carer for Adult B and made a number of decisions on his behalf. There have been assessments of Adult B's ability to make various choices on his own and the outcomes have been very different on each occasion. There were times when his views and opinions was not considered. However there still needs to be the completion of a legal process under the Mental Capacity Act for Adult A to act on Adult B's behalf.

Carers Assessment. As mentioned, Adult A's role in caring for Adult B appears to have been a full time one and as a result she would have benefitted from being offered a Carers Assessment in order that she could be offered support for her own emotional state and welfare and well as being made aware of various support opportunities that may be available to her.

Recommendation 1

The Community Safety Partnership should assess the process of 'Carers Assessments' within agencies providing such a service.

[19] MARAC is a multi-agency meeting where information is shared on high risk domestic abuse cases between agencies, followed by discussing options to increase safety of the victim and agreement of a coordinated action plan.

[20] This subjective commentary has been drawn from the conversations that chair had with Adults C, D & E

5.2 ISSUE OF HINDSIGHT BIAS

As the Overview Report author, I have attempted to view this case, and its circumstances, as it would have been seen by the individuals at the time. It would be foolhardy not to recognise that a review of this type will undoubtedly lend itself to the application of hindsight. Hindsight always highlights what might have been done differently and this potential bias or 'counsel of perfection' must be guarded against. There is a further danger of 'outcome bias' and evaluating the quality of a decision when the outcome of that decision is already known. However, I have made every effort to avoid such approach wherever possible.

5.3 KEY ISSUES

5.3.1 The analysis seeks to review the key issues as identified in the terms of reference, i.e.

- Set out the facts of their involvement with Adult A and Adult B.
  - These details have been combined in a chronology, above.
- Critically analyse the service they provided in line with the specific terms of reference.
  - Analysis of individual agency performance has been addressed by each IMR author and used, as appropriate within this section.
- Identify any recommendations for practice or policy in relation to their agency.
  - Recommendations fall into two categories and are recorded at the end of this report. Those proposed, independently, by Review Panel agencies during the IMR process and those drawn out during the ongoing review process.
- Consider issues of agency activity in other areas and review the impact in this specific case.
  - Matters of activity in other areas have been considered and relevant information included in the combined chronology and analysed within this section.

5.4 ANALYSIS OF AGENCY INVOLVEMENT

5.4.1 BERKSHIRE HEALTHCARE NHS FOUNDATION TRUST (BHFT)

5.4.1.1 BHFT was engaged with Adult B and Adult A over three episodes, between 2012 and 2016. In 2012, Adult A requested that Adult B was referred to the dietician service for weight management advice following his return from the south coast residential care home. Soon afterwards, Adult B was referred by the GP to the Consultant Psychiatrist who worked for the CTPLD. This was as the result of Adult A's request. Adult B was described by Adult A as erratic in his presentation, jumping and shouting. The referral letter made no reference as to whether Adult B had consented to this referral, or if he had seen his GP.

5.4.1.2 Appointments to see the Consultant Psychiatrist were offered in October 2013 and January 2014. Neither appointment was accepted by Adult A who stated that she felt Adult B was fine and that he was settled on his medication and would not require any appointments in the future. A letter was written to the GP by the CPTLD confirming that the referral was closed and that no further appointments would be made. The notes do not demonstrate that the CTPLD ever discussed with Adult B either his wishes or the appointments. There was no obvious exploration of his symptoms or whether they had improved in order that an informed decision could be made. Issues of those acting as a formal carer are discussed in Section 5.6.

5.4.1.3 As Adult B had recently returned home from a period of time in a residential care home this would have been a major upheaval and a review would have been beneficial. There was no evidence that these decisions were overseen by a clinician. Since then, changes have been made to improve service to patients and these are reflected in Section 7 'Early Learning'.

5.4.1.4 In September 2016 a referral was received from the CRHTT, via the Out of Hours GP Services (OOH). Adult C made the referral to the OOH GP service. The police street triage worker attended, and then made a referral for follow up by the CRHTT. The referral had been made by Adult C and described Adult A as being aggressive and violent. Adult C was also concerned for the welfare of Adult B, who lived at home with Adult A. At the same time Adult A called police expressing concerns about Adult C's mental health. Police and a street triage worker visited both Adult A and Adult C on the same date. Adult A would only allow them into the hallway stating that Adult B and the dog were in the lounge. The visit concluded that Adult A was having a "mental breakdown" and a request was made for CRHTT to carry out a follow up visit and consider a Mental Health Act Assessment as required.

5.4.1.5 The subsequent visit, by the CRHTT was carried out the following day and after some persuasion Adult A allowed the team into the house, although again only into the hallway. As such it was only possible for the team to complete a limited assessment. Adult A explained that she found looking after Adult B stressful. She confirmed that she was satisfied with the support provided by the CTPLD and was keen to take more care of Adult B.

5.4.1.6 A risk assessment was completed based upon the observations of the attending clinician and graded Adult A's risk of danger, from others, as medium due to her concerns about Adult C. The assessment of risk presented by Adult A, towards others was graded as low. Adult A's case was closed at this point and a report of this incident was forwarded onto to the GP. The chronology provided by the CCG recorded that the referral was received that day and that three attempts were made to carry out a review of Adult A's mental health. Details of the outcome are recorded under analysis of the CCG.

5.4.1.7 The two attendances at the family home appeared to have had little success in identifying the true picture of life in Adult A's home. The initial report from Adult C was that Adult A was aggressive and violent and he believed her to be having as mental breakdown. This

review has not been able to confirm whether these issues were ever clearly explored despite a number of triggers, including her unwillingness to allow them to see Adult B and only enter a small part of the house.

5.4.1.8 The police triage worker works alongside the police and provides a fast response to reports similar to those made by Adult C. Following similar visits (as appropriate) a referral is made to the CRHTT to progress matters and this was the process followed in this scenario. However a referral to the family's social worker would have ensured all relevant parties were aware of the visit and the challenges faced.

5.4.1.9 The Care Act 2014 (Section 42) requires that each local authority must make enquiries, or cause others to do so, if it believes an adult is experiencing, or is at risk of, abuse or neglect. An enquiry should establish whether any action needs to be taken to prevent or stop abuse or neglect, and if so, by whom.

5.4.1.10 When an allegation about abuse or neglect has been made, an enquiry is undertaken to find out what, if anything, has happened. The findings from the enquiry are used to decide whether abuse has taken place and whether the adult at risk needs a protection plan. A protection plan is a list of arrangements that are required to keep the person safe.[21]

5.4.1.11 In these circumstances the triage worker would be expected to relay the details of what they discovered to staff from the CRHTT. Whilst it is clear that this did take place, the details of what was passed over is unclear. This led to the home visit (recorded on 3.14.10/11). There does not appear to have been any liaison with the family's social worker or others involved with Adult B in order for any safeguarding concerns to be identified by the professionals already involved in his care, and therefore a lack of 'joining the dots'. It is speculation, but had more professional curiosity been demonstrated, by the police, triage worker and CRHTT, the true nature (if any) of the abuse or neglect being suffered may have been discovered and information could have been shared to formulate a protection plan, not just for Adult B but also Adult A.

Learning Point 2
Patient consultation. Throughout this review a theme of consent has been present. Adult A acted on behalf of Adult B and there have been very few incidents where Adult B was directly consulted, instead Adult A acted on his behalf. The review has not found any evidence that Adult A was ever offered the opportunity or completed a carers assessment.

All participating agencies need to review and update their policies and procedures with regards to people acting in the role of carer and ensure that those acting in such a capacity are suitably registered and supported. (See Recommendation 1).

Learning Point 3
Professional Curiosity: There is a need to ensure that all risk is managed, and all available information is gathered and shared. Despite there being two visits by the CRHTT,

[21] https://www.rbsab.org/UserFiles/Docs/F4%20What%20is%20an%20enquiry.pdf

including one with police officers, Adult B was never seen or spoken to. The initial report was made regarding Adult A's mental health. The Review Panel understands that BHFT has amended its previous policy to address these issues and put in place the following actions: Audit of CTPLD records to evidence change relating to improved compliance to Mental Capacity Act and Best Interests decision making; Recruit permanent extra fulltime named professional to continue work of a secondment post on embedding MCA into practice.

A recommendation has been considered in this area but as the BHFT have already identified this and taken action a further recommendation seems rather duplicitous.

Good Practice

5.4.1.12 The interagency agreement between the Police and Health & Social Care agencies (Op Fledge) has been highlighted as a valuable example of good practice and is designed to improve the experience of those in mental health crisis, as well as reducing the number of Mental Health Assessments (MHA) and reducing police time in managing MHA situations as well as overall costs.

5.4.2 THAMES VALLEY POLICE (TVP)

5.4.2.1 TVP had very little contact with the perpetrator prior to his arrest. He did not own a mobile phone or any other communication methods outside the home. He did not leave the house unaccompanied or have a house key. There are no records of Adult B having previously been violent towards his mother or ever calling the police.

5.4.2.2 The police engaged with Adult A and her family on various occasions for a variety of reasons including allegations made by her and Adult C.

5.4.2.3 In November 2006 Police were called to a local day care centre where Adult B attended. Adult E was accused of assaulting Adult B and as result he was arrested. During the investigation a 'DASH Risk Assessment' was completed and the risk presented by Adult E graded as medium. Consideration has been given as to whether this grading was appropriate and a conclusion drawn that bearing in mind Adult E had been arrested (and subsequently left the family home) and Adult A was a protective presence, the grading was appropriate.

5.4.2.4 In May 2009 police were called to an incident where it was alleged that Adult E had grabbed Adult A around the throat. Adult E was arrested, and a DASH risk assessment was completed. The assessment of the risk was graded as medium and there were referrals made to Adult A's GP, ASC and the CMHT.

5.4.2.5 Consideration has been given as to whether a MARAC referral would have been appropriate at this stage and whether these circumstances reached the referral criteria. In terms of temporal sequencing this was the only recorded incident in the calendar year.

The completion of the DASH indicates an element of professional curiosity and the nature of the violence suggests that the risk to Adult A was higher than the risk assessment suggests and so based on the details provided by the IMR a MARAC referral would have been appropriate in these circumstances.

Learning Point 4
MARAC referrals. It would be of great benefit for the completion of a DOM5 record to be accompanied with a subjective assessment of the risk including a holistic view of previous matters relating to perpetrators and victims prior to their relationship beginning and wider questioning of victims in order that the clearest possible view can be taken of the potential for a MARAC referral to be made.

It is recognised it is best practice to engage victims in the DOM5 process. Thames Valley police officers are trained to avoid simply asking victims the questions on the DOM5 form and instead use them as framework for a wider conversation about short, medium and longer terms risks. However, there are incidents where victims choose not to engage and, in these circumstances, officers are now trained to make a professional, subjective assessment based upon the conversations with victims and their own judgement and experience.

The review recognises that since this incident, amendments have been made to the DOM5 process including improvements to the ways in which details are recorded at the scene and subsequently documented and supervised by officers within Thames Valley Police. However, the chair is aware that in other police forces around the country supervisors review historic incidents (of domestic abuse) when considering the risks presented by perpetrators and to victims. This has previously been recognised, by Thames Valley Police service as part of normal day to day practice during the management of domestic abuse cases and therefore no additional recommendation is proposed.

Recommendation 2
Front line practitioners completing DASH or DOM5 risk assessments should also provide an assessment based upon professional judgement alongside the visible high risk. TVP should complete a review of their DOM5 reports to ensure that suitable levels of professional curiosity are demonstrated when completing these records. Assurance should also be sought that staff are trained in providing such professional judgement.

5.4.2.6 In September 2011, Adult A called police to report that Adult C had been making unwanted contact. As part of the initial report, she mentioned that Adult C had threatened to shoot one of her other sons (Adult B or Adult D) in the past. A DASH risk assessment was completed and graded as Standard risk between Adult A and Adult C and the police planned to issue a Harassment Warning letter however Adult A called the police and withdrew her allegation and commented that she was rebuilding her relationship with Adult C. There does not appear to have been any further information gathered about the shooting reference or any onward investigation.

5.4.2.7 In April 2013 Adult A made two reports to the police of unwanted calls, the second being recorded as a 'Domestic Incident' and involved messages being sent to Adult E, believed to have come from Adult C. Adult A told officers that Adult C had previously broken her ribs and she was concerned that Adult C would come to the house and upset Adult B. Adult B's details were not recorded on the subsequent report and therefore were not available for further research, if it were necessary. No DASH risk assessment was completed as the police were unsure whether the incident was a domestic matter.

5.4.2.8 Despite the fact that the source of the calls was never confirmed, Adult A told the officers that she 'believed' them to have come from Adult C. She expressed concerns for her safety and described previous assaults from one of her sons. Therefore, it would have been prudent to complete a suitable risk assessment (DOM5 or DASH) in order that real, potential or perceived risks could have been identified and managed.

Learning Point 5

DOM5 & DASH risk assessments. The DOM5 risk assessment process[22] was introduced in 2013. Prior to this time, TVP used the DASH Risk Assessment process. The SafeLives guidance[23] comments that: "The DASH should be used whenever a practitioner receives an initial disclosure of domestic abuse. As you will be aware, risk in domestic abuse situations is dynamic and can change very quickly. Thus, it may be appropriate to review the checklist with a client on more than one occasion. It is designed to be used for those suffering current rather than historic domestic abuse and ideally would be used close, in time, to the last incident of abuse that somebody has suffered."

The incident in paragraph 5.4.2.7 highlights the need for frontline practitioners to be cautious when considering the need to complete DASH or DOM5 risk assessments. In these circumstances a risk assessment was not completed as it was not clear that the messages had been sent by a family member.

As it transpired the message was from one of Adult A's sons and yet an assessment was never completed and therefore it is of great importance when recording and documenting incidents of domestic abuse and violence, officers ensure that the correct flags and markers are attached in order that suitable referrals and safeguarding measures can be introduced.

Learning Point 6

Record keeping. The incident in April 2013 highlights the need for accurate and thorough record keeping. The fact that Adult B's details were not recorded meant that should any future research or assessment process be carried out, with regards to him then this incident would not be identified. This would adversely affect the information available to those dealing with subsequent information and allegations involving Adult B and should be minimised in the future.

[22] https://www.reducingtherisk.org.uk/cms/sites/default/files/resources/risk/DOM5%202019.pdf

[23] https://safelives.org.uk/sites/default/files/resources/FAQs%20about%20Dash%20FINAL.pdf

This performance issue has been identified by Thames Valley Police. The subsequent Action and Progress has been highlighted in Section 7 'Early Learning'.

During the review there has been contact made with the various residential homes and day care centres which Adult B attended. It is acknowledged that in some cases this was several years ago and outside of the CSP area, however in each case little or no record was available, and this has hampered this review in understanding the full extent of Adult B's treatment, care and lifestyle.

5.4.2.9 On 30th July 2014, the police were called by Adult B's social worker to report concerns that they had witnessed an argument where Adult E had been seen shouting at Adult B. Police officers attended the address and described Adult A as being terrified of Adult E and the officers facilitated the changing of the locks at the house. Adult A did not want to participate any further, declined to take part in the DOM5 questioning and asked the officers to leave before Adult B returned home. Officers graded the risk presented to Adult A, by Adult E, as standard. An incident which began as concerns about Adult E's behaviour towards Adult B became more about Adult A and Adult E, with Adult B not being seen by police. Neither the DOM5 nor the Domestic Incident report recorded Adult B's details, meaning that no risk assessment or onward referral could be made, and that the incident was not searchable against Adult B's name and the risk being monitored was inaccurate due to the lack of details recorded about Adult B.

5.4.2.10 A subsequent call was received by police from Adult B's social worker on 12th August 2014 stating that Adult A and Adult B were distressed following threats from Adult E in the past. An appointment was arranged for two days later for them to visit the police station. At this appointment, no new concerns were raised, a DOM5 was completed in respect of Adult B and an RMO record was created to monitor and manage any subsequent risk.

Learning Point 7

During this review Thames Valley Police have recognised an opportunity to improve their own performance in recording details of those present during the reporting and initial investigation of a domestic incident.

As mentioned above, the officers present at the scene of the matter described in 5.4.2.9, failed to record Adult B's details or carryout an assessment of the risk presented to him. The review understands that amendments have since been made to the police's recording and documenting processes to ensure that details of possible Adults at Risk at domestic incidents are recorded and the initial investigation process assesses the risk presented to, and by, them.

5.4.2.11 It was apparent that Adult A was not keen for the officers to see Adult B. Adult A proposed alternative dates and times to visit, when Adult B was not present as she feared it would upset him and his routine. This reduced the opportunities for the police to identify and manage any safeguarding concerns for either Adult A or Adult B. The issue of Professional Curiosity has been raised in Learning Point 3 above. Additionally, it is one of the police's

core operational duties to protect life and property and it could be argued that Adult A's reluctance to allow Adult B to be seen could have raised an appropriate concern and allowed officers to insist upon seeing him. There is also an option under the Mental Health Act 1983 if there was concern to the safety of Adult B, (Sec 135 MHA 1983 – below).

Learning Point 8
The issue of record keeping, professional curiosity, information sharing, and risk management have been discussed in other learning points. However, the fact that Adult A seemed determined for officers not to be present does raise another question about the possibility of domestic abuse involving parents and their adult children. The incident in September 2016 was the latest in several where Adult A appeared keen to shield the authorities from Adult B. It is unknown whether the reason for this is whether Adult A had a genuine concern that Adult B would be frightened or otherwise impacted by seeing and engaging with authority figures or strangers or in fact she was the victim of domestic abuse by Adult B. This abuse may have been unintended, but the lack of engagement means that it cannot be discounted.

Recommendation 3
All Community Safety Partnership agencies should ensure that on-going training packages include the subjects of domestic abuse between parents and adult children and Professional Curiosity.

5.4.2.12 On 19th August 2014 a further contact was made by Adult A alleging that she had received texts from Adult E threatening to kill her. Officers went to Adult A's home and read the messages. They were deemed to be of a nuisance nature. Adult E was visited, and a Harassment Warning letter was issued. A panic alarm was fitted to the Adult A's home address and a second RMO record created. Two weeks later Adult E sent a further message and Adult A again called the police, who contacted Adult E and advised him that any future contacts should be made through his solicitor. A DOM5 risk assessment was completed and graded the risk as medium but Adult B's details were not entered onto the subsequent police report.

5.4.2.13 In August 2015 police received reports that Adult A was the victim of anti-social behaviour from one of her neighbours (See Radian Housing section). Police officers interviewed both parties and a subsequent behavioural risk matrix score assessed matters as standard. The issue is that there was no subsequent police record created as would have been expected and therefore no retrievable record or details.

Learning Point 9
This series of events reinforces the need for accurate record keeping as has been mentioned above, however as this learning point is based upon the actions of one officer, no additional recommendation is raised.

5.4.2.14 In September 2016 there were a series of calls to the police whereby Adult A and Adult C alleged that each other had mental health problems and as part of a joint initiative (Op

Fledge) Adult A was visited by a mental health professional and police officer and an attempt to complete a mental health assessment was made. Adult A would not allow them beyond the hallway of the house and Adult B, who was in the house was not seen. The subsequent report suggested that Adult A was indeed having a mental breakdown and required a follow up visit. This was followed up the next day by a visit by the Crisis Resolution and Home Treatment Team (CRHTT) who faced the same issue of access to the property and Adult B.

5.4.2.15 The responsibilities of Sec 42 of the Care Act are mentioned earlier (see 5.4.1.9). It is assumed that these 'enquires' were completed as part of this visit and therefore it is a responsibility of those attending to consider the safeguarding of vulnerable adults. The nature of the information, provided by Adult C, meant that this should have been a priority when meeting Adult A. The aims of the safeguarding enquiry are as follows:

- establish the facts about an incident or allegation;
- ascertain the adult's views and wishes on what they want as an outcome from the enquiry;
- assess the needs of the adult for protection, support and redress and how they might be met;
- protect the adult from the abuse and neglect, as the adult wishes;
- establish if any other person is at risk of harm;
- make decisions as to what follow-up actions should be taken with regard to the person or organisation responsible for the abuse or neglect
- enable the adult to achieve resolution and recovery.

5.4.2.16 The visit, which took place the following day, addresses many of these issues however there is no evidence that Adult B was spoken to, independently from Adult A.

5.4.2.17 There is an option (as mentioned above) for police officers and approved mental health professionals to consider applying for a warrant under Sec 135 of the Mental Health Act 1983. The legislation states:

If it appears to a justice of the peace, on information on oath laid by an approved mental health professional, that there is reasonable cause to suspect that a person believed to be suffering from mental disorder —

- *has been, or is being, ill-treated, neglected or kept otherwise than under proper control, in any place within the jurisdiction of the justice, or*
- *being unable to care for himself, is living alone in any such place,*

the justice may issue a warrant authorising any constable to enter, if need be by force, any premises specified in the warrant in which that person is believed to be, and, if thought fit, to remove him to a place of safety with a view to the making of an application in respect of him under Part II of this Act, or of other arrangements for his treatment or care.

The issues regarding this matter have been identified and commented upon within the BHFT section of this analysis. There is a further learning point which may assist in similar circumstances going forward.

Learning Point 10
It's important that all staff from Review Panel agencies are aware of their options when dealing with circumstances where barriers to seeing vulnerable people are identified. The legislation under Sec 42 of the Care Act is an example of what is available to practitioners. The Review Panel is aware that significant improvements have been made in this area, by a number a of agencies and hence the recommendation below suggests that reassurance should be sought that all appropriate staff are trained and competent in this area.

Recommendation 4
The Community Safety Partnership should reassure itself that suitable audit processes are in place to ensure that all staff from Review Panel agencies should receive training on relevant areas of legislation to support them when dealing with similar circumstances.

Good Practice

5.4.2.18 The IMR from Thames Valley Police recognised that there has previously been a need to uplift the response and management of all risk levels including repeat and harassment cases. These include monthly DARIM (Domestic Abuse Repeat Incident Meetings) which stopped in 2019 however and have subsequently been replaced by the MATAC (Multi-Agency Tasking and Coordination)[24] in all LPA's across the Force.

5.4.2.19 The Force has also introduced strategic management and working groups specifically including Domestic Abuse and Safeguarding Adults.

5.4.2.20 As the result of previous Serious Case Reviews (Operation Bullfinch[25]) and DHR's, policing activities and training processes have been reviewed and improved in the area of Safeguarding. The review has identified the following training being delivered to frontline officers and staff:

1) SaVE (Safeguarding, Vulnerability, Exploitation) training programme which began in 2016 with further roll outs and continues beyond the conclusion of this review. The training brings together all aspects of safeguarding and vulnerability.[26]
2) DA Matters[27], from January 2020 TVP are rolling out training to 2,000 members of staff including call handlers, first responders and investigation specialists.

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[24] A multi-agency meeting focusing on a greater sharing of information between police and partners to target those domestic abuse offenders causing the most harm.

[25] www.thamesvalley-pcc.gov.uk/news-and-events/thamesvalley-pcc-news/2015/03/pccs-response-to-the-serious-case-review/

[26] The SaVE programme brings together all aspects of safeguarding in order to ensure that, when responding to incidents, encounter and calls for service, Thames Valley Police is equipped to deal with them effectively. The programme seeks to develop TVP's approach and enhance the professional curiosity of frontline staff. The training incorporates findings and recommendations of internal management reviews, SCR's and developments in the 'Protecting Vulnerable People (PVP) policing environment.

[27] https://safelives.org.uk/training/police

5.4.2.21 The use of a multi-agency approach to visiting those with mental health needs (Op Fledge) has been mentioned as good practice by BHFT and so is also mentioned here.

5.4.2.22 The successful prosecution of Adult E in 2006 was achieved despite the unwillingness of Adult A to support the case and the challenges presented by obtaining evidence from Adult B.

5.4.3 RADIAN HOUSING

5.4.3.1 Radian Housing has a dedicated team of Community Safety Officers who are responsible for managing reports of domestic abuse. They receive training from both internal and external sources. Radian has a specific Domestic Abuse policy and has been awarded DA accreditation by the Domestic Abuse Housing Alliance (DAHA).

5.4.3.2 There are no recorded incidents of domestic abuse however there are several incidents worthy of note as they appear to be increasing the stress levels of Adult A, Adult B and potentially Adult C. They mainly focus upon reports of anti-social behaviour incidents and the perception by Adult A of poor provision of service from Radian.

5.4.3.3 In August 2015 Adult A reported a series of anti-social behaviour incidents whereby Adult B and Adult A were both verbally abused by a neighbour. Adult A reported this was affecting her emotionally. She also reported that Adult C had been shoved by the same neighbour. The police and Adult B's social worker had reportedly been involved at the time of incidents and it was during a phone call between Adult A and the Neighbourhood Officer that it was established that these incidents had occurred over the previous 5 years.

Learning Point 11
The fact that Adult A had not reported any of these matters for such a length of time would be a cause for concern. However, the 'Good Practice' below suggests that awareness amongst employees has been increased and the likelihood that similar incidents will be identified and reported much sooner in the future. There is no reason to believe that the facts are not accurate and therefore these must have increased the stress levels for Adult A and other members of the family. There appears to have been engagement with the police and Adult Social Care which is reassuring.

5.4.3.4 The Radian Neighbourhood Officer met with Adult A and Adult B's Social worker and indicated that mediation between the two parties was the only route available. This was not agreed but, instead, the Neighbourhood Officer wrote to both parties about their behaviour and the matter was to be closed. There is no record that this information was shared amongst other CSP agencies and although the police and ASC were already aware, it would have enhanced the service had others known about these incidents to inform subsequent decision making.

Learning Point 12
The issue worth raising here is one of information sharing. There are incidents here where vulnerable adults were not engaging with the Neighbourhood Officer, and this may have increased safety concerns. It seems to be a missed opportunity that matters such as this and domestic abuse reports are not reported through a multi-agency portal e.g., the MASH.

Recommendation 5
Agencies to share all relevant information regarding anti-social behaviour and domestic abuse, on a case by case basis, through an information pathway agreed with the Community Safety Partnership.

Good Practice

5.4.3.5 Radian Housing has developed the 'See something, Say something' protocol where members are encouraged to report safeguarding concerns.

5.4.3.6 All staff receive mandatory 3 yearly safeguarding training.

5.4.3.7 Radian has a specific Safeguarding Vulnerable Adults and Children's policy.

5.4.3.8 Adult A's Neighbourhood Officer established an effective relationship ensuring that she received thorough and sensitive service whenever contact was made.

5.4.4 PRIMARY CARE

5.4.4.1 Adult A and her family had been registered with the GP surgery for over 22 years. Adult A had not seen her doctor for 3 years prior to her death.

5.4.4.2 Following the incidents mentioned earlier in September 2016 involving the deployment of the Out of Hours GP service and subsequent visit to Adult A's home by the police and mental health professionals, the matter was passed to the GP surgery where efforts were made to get Adult A to attend a mental health review. Telephone calls were made in September, November and December 2016. After initially telling the GP practice that she was fine and had no mental health concerns she did not return the two subsequent messages. There was no further contact with Adult A prior to her death.

Learning Point 13
It is not clear whether the efforts to engage with Adult A were ever shared or if other opportunities were explored (with other agencies) to check on the welfare of Adult A and Adult B and carry out a further assessment of their mental health.

5.4.4.3 With regards to Adult B, he was diagnosed with mental health needs and learning difficulties from an early age, and it is noted that there are no patient records at the GP

surgery for the period of 2008 – 2012 as he was resident in a care home on the South Coast.

5.4.4.4 Primary Care offer annual health checks to people with a learning disability. Attending these health checks is entirely voluntary and although Adult B was offered these, Adult A decided not to bring Adult B to them. It has been questioned, by the Review Panel, about whether Adult A was acting in the best interests of Adult B when not accepting the offer of these health checks.

5.4.4.5 The GP did not feel that Adult B had a particularly complex or a long-term history that would cause any concern to the GP about his physical condition. However, concerns have been raised by the GP about the transfer of information (including the risk management strategy) following his return home after an extended period at the residential care home on the south coast. There was no transfer of information and therefore it was extremely difficult to formulate a new multi-agency care plan and manage any risk presented by or to Adult B.

Learning point 14

The issue of shared information is re-visited here. GP records show that Adult B had very little history at the surgery and therefore it would make sense that the GP was not concerned about him missing the annual checks mentioned above.

Upon returning home, Adult B, Adult A and the GP surgery would have greatly benefitted from receiving a form of 'handover' of records from the home where he had been resident for several years.

This review strongly supports the use of annual health checks for those with learning difficulties and feel that doctors should have access to all available reports and information so that in the event of a patient declining such a review, GP's will be better equipped to encourage participation.

There needs to be an understanding that when service users with mental health conditions similar to Adult B's are being transferred from specialist care home, and similar environments, it is crucial that appropriate medical and safeguarding records are provided to those who will be responsible for their ongoing care, including GP surgeries. A recommendation was considered however it was felt by the Review Panel that no single agency could be tasked with this as it is about wider learning amongst all agencies. Agencies may or may not be aware of a service user leaving a placement and/or returning to reside from a placement and individuals do not have to register with a GP. The learning point is more about when a transfer of care takes place, agencies and individuals (at either end) should ensure the appropriate records are shared.

Good Practice

5.4.4.6 The GP surgery demonstrated a good level of pro-active support and attempts to engage with Adult A a number of times, despite her reluctance. The GP continued to engage with Adult A, via the telephone, despite her reluctance to visit the surgery.

5.4.5 ADULT SOCIAL CARE (ASC)

5.4.5.1 RBWM ASC records show detail of Adult B's upbringing as being a challenging one. He experienced a number of behavioural issues including self-harming and sexual attraction to children. Adult B would often bite himself and bang his head against the wall. His sexualised behaviour demonstrated itself in public places, watching girls as well as following and spying on other vulnerable people. He was also prone to aggressive behaviour.

5.4.5.2 Adult B's case was managed by the Community Team for People with Learning Difficulties (CTPLD) and he was known to them from 2005. The learning point below refers to very little detail being recorded in the IMR. This has been challenged by the chair and it has been acknowledged that during the early period of this review the record keeping, regarding Adult B's case was poor, however it is acknowledged that:

a) some of the cases occurred over 15 years ago and therefore it would be unfair to judge performance then against processes now;
b) The introduction of the Bracknell Forest and Windsor & Maidenhead Safeguarding Adult Board Multi-Agency Risk Management Framework[28], available for use since September 2018 "promotes a robust, proactive partnership approach".

Learning Point 15
During periods of the review the recording of information appears to be limited and the IMR reporting appears to be vague. The chair is confident that as many of these records are over ten years old, processes have improved however this is worthy of raising in order that the CSP can be reassured that this is the case.

Recommendation 6
The Community Safety Partnership should seek to confirm that record keeping within Adult Social Care is accurate and relevant and reassure itself that standards of accuracy and detail are continually maintained.

5.5 SEXUALISED BEHAVIOUR

5.5.1 There are number of incidents worthy of mention with the intention of learning lessons:

[28] https://bfrbwm.safeguardingadultsboard.org.uk/sab/information-for-professionals/multi-agency-risk-framework

- Between July and September 2005, a member of the public reported seeing Adult B touching himself in the showers at a local swimming pool. It appears that the matter was investigated by the college where Adult B attended.

- In September 2006 Adult A contacted the CTPLD and informed them that whilst out walking with Adult E, Adult B was alleged to have engaged in sexualised behaviour in front of two children and their family. Adult B was asked to leave. The CTPLD discussed the matter with Adult A and a referral was made to a psychologist. Adult B was attending a local day care centre and their review indicated that 1-1 support would be put in place and would continue whenever Adult B was in the community, in order to reduce the risk of similar incidents in the future.

- In January 2010 Adult B was living at a residential care home on the south coast. He locked a female service user in his room. Staff managed to open the door and searched Adult B's room where they found pictures of young children which Adult B appeared to have ejaculated on. It appears that the care home dealt with the matter by updating its risks assessments.

- A local social club was organised by the Berkshire Autistic Society and it was there that Adult B met a particular female service user who he indicated he wanted to be his girlfriend. Adult B had a particular interest in small women and this service user fitted the description. Adult B was known to identify women as potential girlfriends and found it hard to understand when they did not reciprocate these feelings. This appeared to cause Adult B issues when they were in his company. Eventually this service user left the club and at the time it appeared that Adult B accepted this.

- In February 2016, whilst on a social club outing, Adult B was observed touching himself in the presence of the female service user and a third club member. The information provided by the police is that when they interviewed Adult B about why he had attacked Adult A, causing her death, there was an inference that it had something to do with her trying to discuss his relationship with the previously mentioned female service user and not these particular circumstances.

5.5.2 "People with an Autism Spectrum Condition (ASC) can have difficulty understanding others' body language, facial expressions and tone of voice. In addition, they may not be aware that their own behaviour is inappropriate and that it can be distressing for others. Watching TV and films, children often witness scenes of a sexual nature. A child with ASC may easily misinterpret these and develop an unrealistic notion of how relationships develop"[29].

[29] Inappropiate-Sexual-Behaviour-2018.pdf (cambiangroup.com)

Childhood

5.5.3 Explaining sexual issues to children can be a daunting task but it is crucial that children with ASC are taught this clearly and calmly and in a way that they understand. If a particular behaviour is not acceptable at age 18, it may not be acceptable at age 8 and this is the time, or earlier, to start teaching appropriate behaviour or alternative behaviour. It can be challenging for parents, carers, and professionals to address or manage such behaviours without restricting an individual's choice and freedom regarding their sexuality. However, if left unattended such behaviours that might be considered inappropriate in childhood or adolescence can become harmful to others in later life and might bring the individual to the attention of the police.

5.5.4 Sometimes adults will allow a younger child with ASC to do something of a sexual nature because it may seem funny or 'they don't mean anything by it' or because the adult feels uncomfortable addressing the issue. This will not help the child for the future, in fact it can be considered to be highly damaging. A child can become vulnerable to abuse if they are allowed believe that cuddling, kissing someone in the lips or masturbating in the presence of others is acceptable behaviour. A child with ASC, even more than other children, may need to be taught that there are certain rules about how we behave, which can help keep them and others safe, such as with whom sexual concerns can be discussed. It might be easier for some to write their sexual/ relationship concerns down in a specified book and have an appropriate adult write the answer in the same book. This may work if the child does not want to voice their query. To simply refer to them as naughty or rude can have an adverse effect upon a child's sexual identity later[30].

Adulthood

5.5.5 In health and social care settings, sexual behaviours may be directed towards support staff, carers, or other services users. In the community, they may be directed towards children and young people. It is important to ensure that these risks are managed (see below) and staff or carers are aware without the individual feeling persecuted, or their privacy breached.

5.5.6 Some individuals, despite undergoing treatment, may still need external management strategies. However, it is vital that these are as unrestrictive as possible for example, increasing community supervision or going out at quieter times rather than denying access to the community.

5.5.7 Recovery and rehabilitation require understanding and acceptance of past mistakes by both the perpetrator and society. Providing motivation and support to move forward, promoting 'healthy' (and legal) sexual behaviours, and striving for the 'Good Life' are important messages in addition to emphasising the negative consequences of abusive behaviours.

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[30] Commentary drawn from www.cambiangroup.com/media/1474414/Inappropiate-Sexual-Behaviour-2018.pdf

5.5.8 Advice is provided by various organisations[31] to aid those supporting individuals demonstrating such challenging behaviours for example:

Do

- Remember that it is a minority of children, young people and adults with learning disabilities or autistic people that display harmful or abusive sexual behaviours.

- Think about why or how the behaviour has developed. Is there a risk that the individual has been abused themselves? Do they need sex education or information about appropriate social conduct? Do they have additional mental health needs?

- Seek help and guidance. Look for age-appropriate, specialist multi-agency treatment for children, and programmes adapted for adults with learning disabilities or autistic people.

Don't

- Ignore concerning behaviours. Many adults who sexually abuse others have long histories of worrying or inappropriate sexual behaviours

- Treat healthy or developing sexual behaviours as abnormal or wrong. Adults and young people with learning disabilities and/or autistic people have the same right to develop their sexual identity, interests, and behaviours as those without.

- Forget about other areas of the individual's life - think about the individual's strengths and communication preferences when working with them and focus on positive behaviours as well as risks.

5.5.9 It is unclear, from early records available to this review, how these situations were managed, in terms of safeguarding, risk management and long-term planning to address the risks presented by Adult B's behaviour. It is not clear how much information was shared and whether a multi-agency approach was adopted but from the research mentioned above it is clear that an early intervention with the family may have helped in recognising these issues and supporting the family in helping Adult B to learn the necessary lessons about his behaviour.

Learning Point 16
It is important that all agencies working with individuals and families that have ASC issues, understand not only the physical and emotional challenges but equally the methods and processes required to ensure that they have a full and active place in the community.

[31] www.choicesupport.org.uk/about-us/what-we-do/supported-loving/supported-loving-toolkit/harmful-sexual-behaviour

This publication[32] highlights how important it is that, during adolescence, a child with similar issues to Adult B needs to have clear direction and understanding in the area of sexualised behaviour. The review finds no reason to suggest that Adult B was not provided with such detail however in the spirit of improving services the CSP should seek reassurance that the parents of children with ASC are suitably supported in understanding such needs. The Review Panel has been provided with reassurance that suitable policies and procedures have been put in place to deal with these issues and a recommendation has been created to ensure that they are appropriate in the addressing the identified need.

Recommendation 7
The Community Safety Partnership should seek reassurance that service users are receiving the necessary support and that front-line practitioners are suitably trained in two subject areas of sexualised behaviour:

i) The need for parents and family members to understand their role in providing boundaries and guidance to support those with ASC in understanding what appropriate behaviour is and isn't.

ii) The processes to be followed when service users demonstrate acts of sexualised behaviour which involve breaches of criminal law, including the Human Rights Act.

5.5.6 In terms of sharing information, it is clear that the police were not informed of any of these incidents and these matters appear to have dealt with internally. Risk has been assessed and updated although specific details are not available on every occasion, however the CPTLD did introduce a process of 1-1 supervision whenever Adult B was out in the community.

5.5.7 The NICE (National Institute for Health and Care Excellence) principles provide an overview of managing 'Harmful sexual behaviour among children and young people'. Once an individual has been identified (i.e. a person under the age of 18 or 25 who has special educational needs, or a disability, displays inappropriate sexual behaviour) a framework of safeguarding and information process should be introduced. The menu of options is listed below:

- Local multi-agency safeguarding arrangements
- Multi-agency approach
- Information sharing between agencies
- Universal services and how to escalate concerns
- Early help assessment
- Specialist assessment and interventions.

5.5.8 Direct consultation with the Adult Social Care department confirms that a local multi-agency safeguarding process is in place and that there are safeguarding policies and procedures in place for staff and volunteers to respond appropriately to any concerns of abuse or neglect they may encounter with children or adults.[33]

[32] www.cambiangroup.com/media/1474414/Inappropiate-Sexual-Behaviour-2018.pdf
[33] https://rbwmsafeguardingpartnership.org.uk/p/safeguarding-adults/safeguarding-policies-and-procedures-1

5.5.9 Discussions with the CTPLD team confirm that whilst historical matters such as those summarised in points 1, 2 & 3 (of paragraph 5.5.1) were dealt with 'in house', records of risk management strategies and interventions are extremely limited.

5.5.10 In 2018 the Bracknell Forest and Windsor & Maidenhead Safeguarding Adults Board introduced a Multi-Agency Risk Management Framework for situations involving risks to service users. This has been produced following previous Safeguarding Adult Reviews and is in line with the early intervention and prevention principles of the Care Act 2014. The role of the framework is to, provide:

- Transparency in identifying risk and its management
- A common set of standards and principles
- Clear actions for named individuals
- A clear process of ownership and accountably

5.5.11 The Framework allows for any lead agency to initiate a multi-agency meeting in order to discuss known information, prepare a risk assessment and agree a suitable action plan, with identified roles and responsibilities. Agencies are encouraged to invite service users and their families to attend this and subsequent meetings in order to secure the support of the wider family unit. Subsequent meetings are designed to review progress, identify other issues and consider alternative approaches as required.

5.5.12 The CTPLD now fully engage with this process and take a proactive approach to support service users in controlling their own lives, whilst recognising their duty of care responsibilities. There is an expectation of timely and appropriate information sharing including risk management and safeguarding matters. The Framework seeks to recognise those who have traditionally fallen outside of statutory criteria, including Sec 42 Care Act cases and others with complex and diverse needs.

5.5.13 Incidents similar to the ones highlighted above would now be subjects for the Multi-Agency Risk Management Framework to consider and engage. Quite clearly matters such as sexually inappropriate behaviour in public should be referred to the police and it is important the service user understands the significance of their behaviour (as mentioned previously).

Learning Point 17
The Multi-Agency Risk Management Framework appears to be an active process; however, the review has not seen any detail and so the CSP and Safeguarding Partnership needs to reassure itself that it is maximising its capacity and ability. The review is aware that the Safeguarding Partnership is monitoring the implementation of the framework.

Recommendation 8
The Strategic Adult Safeguarding Coordinator should be alerted each time an agency or service user enters the Multi-Agency Risk Management Framework process to ensure they can provide an active and reactive role.

5.5.14 The analysis has identified and theme of Adult B's mental capacity and the processes by which he was engaged by health care professionals in the decisions made around his care and treatment. The Mental Capacity Act (MCA) came into force in 2007 and so it would be inappropriate to consider examples before then. There are several examples where Adult B's capacity does not appear to have been assessed and indeed Adult A has been seen as the final decision maker on her son's behalf. For example, the decisions to place Adult B into, and then remove him from the local day care centre and college, the placement into the south coast residential care home in 2008 and removal in 2012. Also, decisions taken by Adult A not to have a full psychiatric assessment in 2016 or allow Adult B to have Learning Disability health checks as were offered by the GP surgery all appear to be decisions which would have benefitted from a formal consideration of whether Adult A or Adult B was capable or able to make these decisions, bearing in mind their diagnosed conditions and medical history.

5.6 WHAT IS MENTAL CAPACITY AND WHEN MIGHT IT NEED TO BE ASSESSED?

5.6.1 Having mental capacity means that a person is able to make their own decisions. Assessments should always start from the assumption that the person has the capacity to make the decision in question (principle 1). The assessor should also be able to show that they have made every effort to encourage and support the person to make the decision themselves (principle 2). The assessor must also remember that if a person makes a decision which the assessor consider eccentric or unwise, this does not necessarily mean that the person lacks the capacity to make the decision (principle 3). Under the MCA, the assessor is required to assess capacity before carrying out any care or treatment – the more serious the decision, the more formal the assessment of capacity needs to be.

5.6.2 The assessor might need to assess capacity where a person is unable to make a decision.

1) Does the person have an impairment of their mind or brain, whether as a result of an illness, or external factors such as alcohol or drug use?
2) Does the impairment mean the person is unable to make a specific decision when they need to? People can lack capacity to make some decisions but have capacity to make others. Mental capacity can also fluctuate with time – someone may lack capacity at one point in time but may be able to make the same decision at a later point in time.

5.6.3 Assessments are made on the balance of probabilities and every effort should be taken to help those being assessed to engage in the process. It is best practice for decisions such as those to be carried out by professionals, including doctors and social workers and those with full time carer's responsibilities.

5.6.4 Later in the chronology there are examples where assessments did take place, including:

- In September 2012 when the CTPLD assessed Adult B's ability to make decisions about attending social functions. During the same period there was an assessment to help Adult B decide whether to remain at the south coast residential care home.

- In July 2015 Adult B was assessed as to whether he was capable of deciding whether to have contact with his biological father.
- In October 2016 where Adult B was assessed as to whether he was capable of deciding whether he wished to attend a local day care centre.

5.6.5 The outcome of these assessments is confusing in that one of the results was not recorded, one confirmed that Adult B was capable and the other concluded that he wasn't. Whilst no two circumstances are the same, the guidance is quite specific and the reports to the Review Panel do suggest that opportunities were missed.

Learning Point 18
It is clear that the process of assessment under the Mental Capacity Act has improved over the period of this review and that service users are being encouraged to engage in decisions which effect their daily lives and long-term care. However, this review provides a very small sample size.

Initially a recommendation was proposed that a review of the assessment capacity framework should be carried to ensure that the five key principles were adopted and that 'best interest' decisions were being made. However, it has been confirmed that such reassurances have previously been made to the Adult Safeguarding Board and that any related recommendation is no longer warranted.

5.7 MARAC AND INFORMATION SHARING

5.7.1 The MARAC process is designed to provide a multi-agency response to domestic abuse cases considered to be High Risk. There are three basic principles which are used to interpret when an incident or set of circumstances should lead to a MARAC referral:

1. Visible High Risk - 14+ yes answers to the DASH checklist.
2. Professional Judgement.
3. Potential escalation of the risk being apparent during a series of reports or engagements.

5.7.2 Analysis of the incidents which could be interpreted as domestic abuse, over the review period averages out at just over 1 a year (15 incidents over 12 years) and perpetrator and victim were varied. Therefore, it is reasonable to judge that a referral into the MARAC process was never likely, other than the one potential incident mentioned in 3.7.2. However, there was clearly a need for a separate process to deal with cases that fall outside the MARAC framework.

5.7.3 The Review Panel has confirmed that there is a separate multi-agency framework whose role is to discuss those complex/repeat cases that do not meet the MARAC threshold. Initially this was the monthly DARIM (Domestic Abuse Repeat Incident Meetings) which stopped in 2019 and has subsequently been replaced by the MATAC (Multi-Agency Tasking and Coordination) in all LPAs across the Force. The MATAC focuses on providing

a forum for agencies to discuss complex cases, sharing information and checking its accuracy. The meeting focuses upon tackling harmful and serial domestic abuse perpetrators that do not reach the MARAC threshold.

5.7.4 It appears that cases similar to Adult A and her family would have greatly benefitted from a referral to the MATAC meeting. The Multi-Agency Risk Management Framework, mentioned in the discussion of Adult B's sexualised behaviour, focuses upon the risks presented by a service user, whereas the MATAC meeting could consider a more holistic view of the whole family and the risk presented by the impact of various safeguarding issues including mental ill health, disability, dysfunction, separation, caring responsibilities, and domestic abuse. During the analysis it has been recognised that, at some point, all of the family members has been reported as either a suspect and/or a victim. This family has been troubled for many years and a multi-agency, problem solving approach was required. The MATAC appears to be an extremely useful and relevant forum for future situations, similar to this, to be presented and managed.

5.7.5 The work of the MATAC meeting is crucial in managing risks and identifying themes of abuse within particular families. All member agencies must ensure that they identify opportunities to refer cases into this framework and recognise opportunities to support cases brought by other agencies.

5.7.6 What was not clear to this review, was what services or referrals were offered (particularly to Adult A) when matters of domestic abuse were reported, or apparent. This was discussed at Review Panel meetings and reassurances provided, by each agency that these lessons have been learned previously and no additional recommendation is required. Whilst the chair is confident that this is the case, the MATAC forum would be able to consider the services that were offered to victims of domestic abuse including IDVA's and other commissioned services.

Recommendation 9
The Domestic Abuse Executive Group should work with MATAC to continue to raise awareness of its function amongst frontline practitioners, review panel membership and ensure that all relevant agencies are represented.

5.7.7 It has been acknowledged by members of the Review Panel and other agencies that incidents which occurred at the early stages of this review period were not widely disclosed and in fact there was an element of silo working by individual agencies. For example, the incidents of Adult B's sexualised behaviour and assaults on Adult A in 2006. Each of these incidents, along with several others would have benefited from being shared with a wider audience, across the CSP. As has been discussed previously there is now a much wider network of forums which can be used to share such information and allow for necessary safeguarding and risk assessments to be completed.

Good Practice

5.7.8 This review has identified that Adult A had a good working relationship with the CTPLD key staff worker and team leader, including regular contact and information sharing.

5.7.9 The CTPLD were very pro-active when supporting Adult A, Adult B and Adult D after Adult E left the family home in 2014. Support included respite workers for Adult B, support with housing and rent issues and financial support for clothing and Christmas gifts.

6. CONCLUSION AND LESSONS TO BE LEARNED

6.1 Adult A was a loving and caring mother of three sons. Throughout her life she faced various challenges but always sought to ensure that the care for her children was paramount. Tragically it was that devotion that led to her death. The comments from her ex-partner Adult E, during his interview with the chair confirm this view.

6.2 For those close to Adult A the tragedy is made all the more difficult as the perpetrator was her son, Adult B. This has also been highlighted with nature of the engagement between the chair and the three family members he has spoken to. Adult B had been diagnosed with Autism Spectrum Disorder at a young age and though his moods could be unpredictable. It has been a challenge for the Review Panel to understand how circumstances could reach a level where this homicide occurred. Taking all reasonable steps to avoid the bias of hindsight and using the information available to those agencies who were managing the perpetrator the review has identified various opportunities for learning.

6.3 This review has recognised that Adult A was a caring protective mother who appears to have acted in Adult B's best interest throughout his life. However, at the early stages of this review period it was apparent that Adult B's capacity was not always being assessed under the guidance of the Mental Capacity Act. Support in this area may have allowed crucial decision makers to understand the emotions and feelings that Adult B had. Ultimately his feelings towards one particular female may have caused him to fatally assault Adult A.

6.4 Adult A's devotion often demonstrated itself in her desire to care for Adult B in a very private way. She was often reluctant in seeking agency support apparently concerned that such involvement may cause more harm than good. There were several incidents where agencies engaged with the family and had the opportunity to delve deeper into particular circumstances to understand the background and emotional impact of life within the family. On several occasions these opportunities were not seized and have been identified as missed opportunities.

6.5 These matters include: Adult B exhibiting sexualised behaviour; including the use of an occupational therapist who specialised in sex offending; the relationship between Adult C and Adult A; the proposed use of psychiatrists following Adult B's significant weight gain; and various risk assessments including DASH and Adult A's ability to care for Adult

B. These are discussed at various stages in the analysis, which has produced various points of learning and recommendations.

6.5 Particularly at the beginning of the review period, many of the agency's engaging with Adult B and his family appeared to be working alone and with very little sharing of information. This has been picked up on during the analysis phase as has the fact that the CSP has identified this issue. There are now a wide range of panels and frameworks in place to ensure that the broadest information highway is available for agencies to share information and produce a multi-agency approach to care planning and risk assessment.

6.6 On several occasions it has been recognised that record keeping has not been as thorough as it should be. There were incidents where the completion of risk assessment forms failed to record Adult B's presence at a domestic related matter and occasions where circumstances, meetings and formal assessments have been summarised without providing appropriate levels of detail. This has made it difficult for the chair to analyse in detail the service and treatment provided to Adult B.

6.7 In approaching learning and recommendations, the chair of the review panel has sought to do two things. Firstly, to try and understand what happened and consider the issues in Adult A and Adult B's life that might help explain the circumstances of the homicide. Secondly, to use this case to consider a wide range of issues locally, including provision for victims of domestic abuse with mental health and capacity issues.

6.8 The Review Panel would like to extend their sympathies towards all those affected by Adult A's death.

7. EARLY LEARNING

7.1 Several early learning opportunities have been identified and documented by the IMR authors and recorded in their reports. They have been collated and recorded in the table below:

Agency	Learning	Action
BHFT	Professionals need to be aware of their responsibility to dependents when working with an adult who is a carer including those who are not brought to their appointment.	Pathway being developed. Continue to embed a 'Think Family' approach in safeguarding training and advocate Carers assessments.
	Identification of potential domestic Abuse concerns from CRHTT and police triage service.	Team reflective supervision sessions to be offered to these teams.

	Improve Compliance with MCA 2005 and best interest's assessment, Consent to and withdrawal of treatment for CTPLD's.	Audit of records to evidence change.
Radian Housing	Importance of Good Record Keeping.	Training to all appropriate staff.
Adult Social Care	All staff to attend mandatory professional curiosity training.	To ensure that practitioners' respectful uncertainty – apply critical evaluation to any information they receive and maintain an open mind.
	All staff to attend mandatory for domestic abuse and coercive control.	To ensure that all staff attend.
	To review current safeguarding practice in relation to raising a safeguarding concern for a carer who may be experiencing intentional or unintentional domestic abuse.	To ensure that all staff know how to respond when an allegation of intentional or unintentional harm is made by a carer against the person they care for.
Thames Valley Police	There is a potential to overlook how adults at risk, living in households where there is domestic abuse, may be adversely affected by it.	Review the amended software on the NICHE recording system. Operational guidance is already in place.
	Improve response and management of all risk levels including repeat victims and harassment cases.	The introduction of DARIM approaches to managing risk and targeting perpetrators.
	Introduce a process for sharing information provided by vulnerable and 'at risk' individuals during the investigation of domestic abuse incidents and allegations of crime.	Officers are now trained to seek consent, from individuals before information is disclosed or shared with other agencies, however information can be disclosed, without consent, if a subsequent risk assessment

		deems to be proportionate legal, appropriate, and necessary.

8. RECOMMENDATIONS

8.1 IMR RECOMMENDATIONS (SINGLE AGENCY)

8.1.1 The following single agency recommendations were made by agencies during the preparation of their IMR's:

8.1.1.2 ADULT SOCIAL CARE

- Assessment of both carer and service user must include consideration of the wellbeing of both people. Services are to ensure that part of the yearly carers assessment includes a discussion with the carer about their present situation and an assessment of risks posed to the carer from caring with someone known to have a history of challenging behaviours
- For services to recognise that a safeguarding concern for the carer can be raised, if reports are received that they are experiencing intentional or unintentional harm as a result of the support they provide to a person with support needs.
- Professional Curiosity Training to be offered to all Adult Social care staff. Professional Curiosity is a capacity and communication skill to explore and understand what is happening within a family rather than making assumptions or accepting things on face value.
- Increase awareness of domestic abuse and coercive control amongst social care professionals outside of the usual male/female intimate relationship paradigm.

8.1.1.3 RADIAN HOUSING

- In-House Domestic Abuse Training to be provided to front-line staff.
- Anti-Social Behaviour Training to be provided to front-line staff to ensure all notes are recorded effectively and correspondence store appropriately.
- Customer profiling to be enhanced, ensuring that household make up is current.

8.1.1.4 BHFT

- Professionals need to be aware of their responsibility to dependants when working with an adult who is a carer. This pathway is to be developed.
- Further support on identification of potential domestic abuse concerns for CRHTT and police triage to be explored such as reflective supervision sessions.
- Improve compliance with the Mental Capacity Act 2005 and best interests' assessment. Consent to or withdrawal of treatment for CTPLD
- Continue to embed the 'Think Family' approach in safeguarding training.

8.1.1.5 THAMES VALLEY POLICE

- With the introduction of the new Domestic Abuse Risk Assessment online recording function the police strategic unit are to review:
    - How adults at risk are identified and risk assessed and
    - How their details are recorded and shared, when they live in households, where there has been domestic abuse.

Recommendation 10
All agencies report progress on their single agency IMR recommendations to the Community Safety Partnership.

8.2 OVERVIEW REPORT RECOMMENDATIONS

8.2.1 These recommendations should be acted upon through the development of an action plan, with progress reported to the RBWM CSP and the SAB following the review being approved.

Recommendation 1 - The Community Safety Partnership should assess the process of 'Carers Assessments' within agencies providing such a service.

Recommendation 2 - Front line practitioners completing DASH or DOM5 risk assessments should also provide an assessment based upon professional judgement alongside the visible high risk. TVP should complete a review of their DOM5 reports to ensure that suitable levels of professional curiosity are demonstrated when completing these records. Assurance should also be sought that staff are trained in providing such professional judgement.

Recommendation 3 - All Community Safety Partnership agencies should ensure that on-going training packages include the subjects of domestic abuse between parents and adult children and Professional Curiosity

Recommendation 4 - The Community Safety Partnership should reassure itself that suitable audit processes are in place to ensure that all staff from Review Panel agencies should receive training on relevant areas of legislation to support them when dealing with similar circumstances.

Recommendation 5 - Agencies to share all relevant information regarding anti-social behaviour and domestic abuse, on a case by case basis, through an information pathway agreed with the Community Safety Partnership.

Recommendation 6 - The Community Safety Partnership should seek to confirm that record keeping within Adult Social Care is accurate and relevant and reassure itself that standards of accuracy and detail are continually maintained.

Recommendation 7 - The Community Safety Partnership should seek reassurance that service users are receiving the necessary support and that front-line practitioners are suitably trained in two subject areas of sexualised behaviour:

i) The need for parents and family members to understand their role in providing boundaries and guidance to support those with ASC in understanding what appropriate behaviour is and isn't.

ii) The processes to be followed when service users demonstrate acts of sexualised behaviour which involve breaches of criminal law, including the Human Rights Act.

Recommendation 8 - The Strategic Adult Safeguarding Coordinator should be alerted each time an agency or service user enters the Multi-Agency Risk Management Framework process to ensure they can provide an active and reactive role.

Recommendation 9 - The Domestic Abuse Executive Group should work with MATAC to continue to raise awareness of its function amongst frontline practitioners, review panel membership and ensure that all relevant agencies are represented.

Recommendation 10 - All agencies report progress on their single agency IMR recommendations to the Community Safety Partnership.

APPENDIX 1 – TERMS OF REFERENCE

DOMESTIC HOMICIDE REVIEW
TERMS OF REFERENCE

This Domestic Homicide Review is being completed to consider agency involvement with Adult A following her death in December 2017. The Domestic Homicide Review is being conducted in accordance with Section 9(3) of the Domestic Violence Crime and Victims Act 2004.

Purpose

1. Domestic Homicide Reviews (DHR) place a statutory responsibility on organisations to share information. Information shared for the purpose of the DHR will remain confidential to the panel, until the panel agree what information should be shared in the final report when published.

2. To review the involvement of each individual agency, statutory and non-statutory, with Adult A and Adult B during the relevant period of time: from the date of her death and 13 years hence.

3. To summarise agency involvement from December 2004 to the present day.

4. To establish whether there are lessons to be learned from the case about the way in which local professionals and agencies work together to identify and respond to disclosures of domestic abuse.

5. To identify clearly what those lessons are, how they will be acted upon and what is expected to change as a result and as a consequence.

6. To improve inter-agency working and better safeguard adults experiencing domestic abuse. and not to seek to apportion blame to individuals or agencies.

7. To commission a suitably experienced and independent person to:

   a) chair the Domestic Homicide Review Panel;
   b) co-ordinate the review process;
   c) quality assure the approach and challenge agencies where necessary; and
   d) produce the Overview Report and Executive Summary by critically analysing each agency involvement in the context of the established terms of reference.

8. To conduct the process as swiftly as possible, to comply with any disclosure requirements, panel deadlines and timely responses to queries.

9. On completion present the full report to the Local Community Safety Partnership.

10. The Safeguarding Adults Board has agreed that they will not be conducting a separate Safeguarding Adults Review process (see Section 44 of the Care Act 2014) but have requested a widening of the DHR terms of the reference to include safeguarding considerations and will take forward any specific recommendations regarding adult safeguarding.

11. It is not to seek to apportion blame to individuals or agencies**.**

Membership

12. It is critical to the effectiveness of the meeting and the DHR that the correct management representatives attend the panel meetings. Your agency representative must have knowledge of the matter, the influence to obtain material efficiently and can comment on the analysis of evidence and recommendations that emerge.

13. The following agencies are invited to be involved:
    a) Clinical Commissioning Groups
    b) Community Safety Partnership
    c) General Practitioner for the victim and alleged perpetrator
    d) Berkshire Health Foundation Trust
    e) Frimley Hospitals Trust
    f) South Central Ambulance Service
    g) Local Adult Safeguarding Board
    h) AfC – Children's Services
    i) Optalis – Adult Services
    j) Local Mental Health / CCG Partnership
    k) Police (Homicide Investigation Lead / Policy Unit)
    l) Victim Support (including Homicide case worker)
    m) DASH Charity - local domestic violence specialist service provider
    n) Radian Housing Association

14. Where the need for an independent expert arises, for example, a representative from a specialist organisation, the chair will liaise with and if appropriate ask the organisation to join the panel.

15. If there are other investigations or inquests into the death, the panel will agree to either:
    a) run the review in parallel to the other investigations, or
    b) conduct a coordinated or jointly commissioned review - where a separate investigation will result in duplication of activities.

Collating evidence

16. Each agency to search all their records on / outside the identified time periods to ensure no relevant information was omitted and secure all relevant records.

17. Each agency must provide a chronology of their involvement with Adult A and Adult B during the relevant time period. Agencies will also consider Adult C and Adult D (brothers of Adult B) and Adult E (partner of Adult A) within the wider scope of evidence collation.

18. Each agency is to prepare an Individual Management Review (IMR), which:
    a) sets out the facts of their involvement with Adult A and/or Adult B.
    b) critically analyses the service they provided in line with the specific terms of reference
    c) identifies any recommendations for practice or policy in relation to their agency
    d) considers issues of agency activity in other boroughs and reviews the impact in this specific case.

19. Agencies that have had no contact should attempt to develop an understanding of why this is the case and how procedures could be changed within the partnership which could have brought Adult A and/or Adult B in contact with their agency.

Analysis of findings

20. In order to critically analyse the incident and the agencies' responses to the family, this review should specifically consider the following points:
    a) Analyse the communication, procedures and discussions, which took place between agencies.
    b) Analyse the co-operation between different agencies involved with the victim, alleged perpetrator, and wider family.
    c) Analyse the opportunity for agencies to identify and assess domestic abuse risk.
    d) Analyse agency responses to any identification of domestic abuse issues.
    e) Analyse organisations access to specialist domestic abuse agencies.
    f) Analyse the training available to the agencies involved on domestic abuse issues.

Liaison with the victim's and alleged perpetrator's family

21. Sensitively involve the family of Adult A in the review if it is appropriate to do so in the context of on-going criminal proceedings. Also, to explore the possibility of contact with any of the alleged perpetrator's family who may be able to add value to this process. The chair will lead on family engagement with the support of the senior investigating officer and the family liaison officer.

22. Co-ordinate family liaison to reduce the emotional hurt caused to the family by being contacted by a number of agencies and having to repeat information.

23. Coordinate with any other review process concerned with the children of the victim.

Development of an action plan

24. Establish a clear action plan for individual agency implementation as a consequence of any recommendations.

25. Establish a multi-agency action plan as a consequence of any issues arising out of the Overview Report.

Media handling

26. Any enquiries from the media and family should be forwarded to the chair who will liaise with the CSP. Panel members are asked not to comment if requested. The chair will make no comment apart from stating that a review is underway and will report in due course.

27. The CSP is responsible for the final publication of the report and for all feedback to staff, family members and the media.

Confidentiality

28. All information discussed is strictly confidential and must not be disclosed to third parties without the agreement of the responsible agency's representative. That is, no material that states or discusses activity relating to specific agencies can be disclosed without the prior consent of those agencies.

29. All agency representatives are personally responsible for the safe keeping of all documentation that they possess in relation to this DHR and for the secure retention and disposal of that information in a confidential manner.

30. It is recommended that all members of the Review Panel use the DHR Microsoft Teams platform for the sharing of files and set up a secure email system for any other communications, e.g., registering for criminal justice secure mail, nhs.net, gsi.gov.uk, pnn or GCSX. Confidential information must not be sent through any other email system. Documents may be password protected.

Disclosure

31. Disclosure of facts or sensitive information may be a concern for some agencies. We manage the review safely and appropriately so that problems do not arise and by not delaying the review process we achieve outcomes in a timely fashion, which can help to safeguard others.

APPENDIX 2 – GLOSSARY OF TERMS

- AAFDA Advocacy After Fatal Domestic Abuse
- AfC Achieving for Children
- ASB Anti-Social Behaviour
- ASC Autism Spectrum Condition
- ASD Autism Spectrum Disorder
- ASC Adult Social Care
- BHFT Berkshire Healthcare Foundation Trust
- CCG Clinical Commissioning Group
- CMHT Community Mental Health Team
- CRHTT Crisis Resolution and Home Treatment Team
- CSO Community Safety Officer
- CSP Community Safety Partnership
- CTPLD Community Team for People with Learning Difficulties
- DAHA Domestic Abuse Housing Alliance
- DARIM Domestic Abuse Repeat Incidents Meeting
- DASH Domestic Abuse, Stalking, Harassment & Honour Based Abuse (Risk Identification Checklist)
- The Dash Charity Domestic Abuse Stops Here
- DOM5 Thames Valley Police Risk Identification Checklist
- DHR Domestic Homicide Review
- EDT Emergency Duty Team
- GP General Practitioner
- IMR Independent Management Review
- LPA Local Policing Area
- MARAC Multi-Agency Risk Assessment Conference
- MATAC Multi-Agency Tasking And Coordination
- MCA Mental Capacity Act
- NICE National Institute for Health and Care Excellence
- OPCC Office of the Police and Crime Commissioner
- RBWM The Royal Borough of Windsor & Maidenhead
- RMO Risk Management Occurrence
- RMS Records Management System
- SAB Safeguarding Adults Board
- SAR Safeguarding Adults Review
- SCAS South Central Ambulance Service
- ToR Terms of Reference
- TVP Thames Valley Police
- VAWG Violence Against Women and Girls

APPENDIX 3 – CHRONOLOGY OF FAMILY CONTACT

Family Member	Method	Date
Adult C and Adult E	Letter and Telephone	22nd November 2018
Adult D	Telephone	22nd November 2018
Adult C	WhatsApp messages and Telephone	29th November 2018
Adult C	WhatsApp messages and Telephone	30th November 2018
Adult D	Telephone	10th December 2018
Adult C, Adult D and Adult E	Telephone	15th January 2019
Adult C, Adult D and Adult E	Letter	3rd February 2019
Adult E and Adult C	Letter WhatsApp messages	22nd November 2019
Adult C	Telephone	31st October 2020
Adult C, Adult D and Adult E	Telephone	5th November 2020
Adult D and Adult E	Telephone	9th November 2020
Adult C (x2)	Telephone Messages left	11th November 2020
Adult C (x3) Adult E	Telephone Messages left Telephone	16th November 2020
Adult C	Telephone Messages left	17th November 2020
Adult C	Telephone Messages left	22nd November 2020
Adult D	Emails x2 (Sending of the draft Overview Report)	27th November 2020
Adult C	Email	27th November 2020
Adult C	Email	28th November 2020
Adult E	Telephone	28th November 2020
Adult D	Email	7th December 2020
Adult C	Telephone Message Left	8th December 2020
Adult C	Email	7th December 2020
Adult D	Telephone	8th December 2020
Adult C	Email & Telephone Message Left	8th December 2020