DOMESTIC HOMICIDE REPORT

EXECUTIVE SUMMARY

Report into the death of Adult A, December 2017

Report produced by Peter Stride – Foundry Risk Management Consultancy

On behalf of Windsor and Maidenhead Community Safety Partnership

Report Completed 22nd December 2020

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EXECUTIVE SUMMARY

1. THE REVIEW PROCESS

1.1 This summary outlines the process undertaken by The Royal Borough of Windsor and Maidenhead's Domestic Homicide Review Panel in reviewing the homicide of Adult A by Adult B (her son). Both were residents in the area at the time of the homicide.

1.2 This review has been suitably anonymised in accordance with the statutory guidance.

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

1.3 Criminal proceedings were completed in September 2019 and the perpetrator was sentenced under Section 37 (Hospital Detention Order) of the Mental Health Act 1983, with Section 41 restrictions. Subsequently the Coroner suspended the inquest permanently and decided not to hold an inquest.

1.4 The decision to hold a Domestic Homicide Review was made on 1st August 2018 and the initial Review Panel meeting took place on 29th October 2018.

1.5 All agencies that potentially had contact with Adult A, Adult E or their (step) children prior to the point of death were contacted and asked to confirm whether they had had any involvement with them.

1.6 Eight agencies contacted confirmed contact with the victim and/or perpetrator and children involved and were asked to secure their files.

1.7 The review was conducted in accordance with the statutory guidance under Section 9(3) of the Domestic Violence, Crime and Disorder Act (2004) and the expectation of

the Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews December 2016.

1.8 Background information, from the following was added in order to try to build up a picture of the local context:

- 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 guidance regarding the Mental Capacity Act 2005
- The local Multi-Agency Risk Management Framework 2018

2. CONTRIBUTORS TO THE REVIEW

2.1 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 Social Care (CSC), RBWM	IMR & Chronology
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

2.2 Independence and Quality of the IMR's: The IMR's were written by authors who were independent of case management or service delivery to those concerned. 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.

3. THE REVIEW PANEL MEMBERSHIP

Agency	Name	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 Social Care, RBWM	Director of Children's Social Care
Jo	East Berkshire Clinical Commissioning Group (CCG)	Named Professional, Safeguarding, Children and Adults
Karolyn	Radian Housing Association	Housing Manager
Jane	Berkshire Healthcare NHS Foundation Trust	Head of Safeguarding
Stefan	Thames Valley Police	Detective Inspector
Claire	The Dash Charity	Advocacy and Outreach Services Manager
Antony	South Central Ambulance Service (SCAS)	Head of Safeguarding

3.1 The Review Panel met 6 times: 29th October 2018, 14th January 2019, 6th June 2019, 4th September 2019, 19th August 2020 and 8th October 2020. As mentioned above, the Review Panel members and IMR authors were independent of any case management or service delivery to those concerned. As per the statutory guidance, the chair(s) and the Review Panel are named, including their respective roles and the agencies which they represent.

4. CHAIR AND AUTHOR OF THE OVERVIEW REPORT

4.1 Peter Stride was appointed by the Royal Borough of Windsor and Maidenhead Community Safety Partnership as Independent Chair of the Review Panel and Author of this Domestic Homicide 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 the boroughs of Westminster Brent and Harrow.

4.2 As Detective Chief Inspector he has been the vice chair of two Local Adult and Children's Safeguarding Boards and was responsible for the creation and implementation of various MASH (Multi-Agency Safeguarding Hub) and MACE (Multi-Agency Child Exploitation) panels as well as chairing MAPPA (Multi-Agency Public Protection Arrangements) and MARAC (Multi-Agency Risk Assessment Conference) meetings.

4.3 Since retirement, Peter has established his own business consultancy, coaching and training in a range of risk management environments focusing upon child and adult safeguarding within the public sector.

4.4 Mark Wolski was appointed by the Royal Borough of Windsor and Maidenhead Community Safety Partnership as Independent Co-Chair of the DHR Panel. He is a former Metropolitan police officer with 30 years operational service, retiring in February 2016. He served mainly as a uniformed officer, holding the role as Deputy Borough Commander at the Boroughs of Haringey, Harrow and at the Specialist Operations command of Aviation Security. During his service he gained significant experience leading the response to Domestic Abuse, Public Protection and Safeguarding. Mark has subsequently acted as a consultant in the field of Community Safety, Independent Chair of a MARAC Steering Group and as a DHR chair/co-chair

4.5 Peter and Mark have completed Home Office approved DHR training and have attended subsequent DHR chair training by Advocacy After Fatal Domestic Abuse (AAFDA).

4.6 Neither Peter nor Mark have any connection with the Royal Borough of Windsor and Maidenhead Community Safety Partnership.

5. TERMS OF REFERENCE FOR THE REVIEW

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

5.2 The Review Panel comprised of 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 this process, ensure their participation and the need to secure their records.

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

5.4 *Key Lines of Inquiry:*
The Review Panel considered both the 'generic issues' as set out in the statutory guidance and identified and considered the following case specific issues:

- Set out the facts of their involvement with Adult A and Adult B
- Critically analyse the service they 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

5.5 At the first meeting, the Review Panel shared brief information obtained from a 'summary of contact' exercise about agency contact with the individuals involved. At this early stage it was clear that there had been engagement with a variety of agencies who had focused mainly, with regards to Adult B, on his mental health issues and little about domestic violence or coercive control involving either Adult A or any other family members. Adult B had never directly contacted any Community Safety Partnership (CSP) agency, but the unpredictable nature of the relationships within the family unit led to engagement with a number of agencies. It was also apparent 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 between December 2004 and the date of Adult A's death. Where appropriate, information about the relationship outside of this time period is included to provide context.

6. SUMMARY OF CHRONOLOGY

6.1 Adult B was one of Adult A's three sons, his father had left the family home some years previously. At a young age Adult B was diagnosed with Autism and hyperactivity and this was formally recorded, along with frequent seizures, in 2001. His condition was managed with regular medication.

6.2 There was very little engagement with the family during this review. No further extended family members, friends, neighbours or other witnesses came forward as part of the police investigation. After consultation with the police Family Liaison Officers the decision was taken, by the chair, to attempt contact with Adult A's youngest son, Adult D. The Overview Report highlights the issues presented by contacting Adult E and Adult C and that their own mental health challenges combined with their role within the report may have a significant impact on their lives subsequently. The police investigation had also recognised the challenges presented by liaising with both stepfather and older brother. Several conversations took place between the chair and Adult D, and it was obvious that he felt upset and uncomfortable discussing this incident. Adult D was provided with details of AAFDA (Advocacy After Fatal Domestic Abuse) and encouraged to seek their support. In consultation, with the Review Panel, the chair took the decision to disengage with Adult D until the end of the review, in order to allow a further period of grieving. Contact was re-established with the family in October 2020 with details of these conversations being outlined in the Overview Report.

6.3 Family Perspective

6.3.1 Adult D and Adult E were both interviewed during the police investigation, and both recognised that Adult B's condition required day to day support and that he had spent time living in residential care. Both described Adult B as having a bad temper which had recently got worse. He self-harmed by biting and hitting himself and he had started throwing items around the home.

6.3.2 Adult A and Adult E had met in 2006 and married in 2007. At the time, Adult A's eldest son, Adult C, lived at home but had moved out shortly after Adult E had moved in. The combined chronology recognises that Adult E and Adult B were involved in a number of aggressive and violent confrontations which resulted on one occasion with Adult E being arrested and finally with him leaving the family home.

6.3.3 There was little evidence to suggest that Adult A was ever the victim of physical domestic abuse at the hands of Adult B although there was report to ASC by Adult A that Adult B had kicked her in the back resulting an injury whereby, she visited hospital. There were also several reports were made by Adult A about the behaviour of Adult C,

after he left the family home and Adult E, both before and after his relationship with Adult A had ended.

6.3.4 The Review Panel considered the likelihood of Adult A being a domestic abuse victim with Adult B as the perpetrator and whether he had the mental capacity to perpetrate such an act. The chronology and IMR's leave this subject slightly confused as the three assessments of Adult B's capacity produced three separate outcomes. It is worth pointing out that there were no formal recorded reports of Adult B assaulting, abusing or harassing his mother.

6.3.5 At the end of the review process, contact with the family was established and the chair interviewed Adult C, Adult D and Adult E. The two brothers of the perpetrator expressed support of the review process but were unwilling to discuss details of their upbringing or any incidents which occurred during this review period. Adult E has provided details of his relationship with Adult A and her three sons. He discussed life in the family home as often being a struggle and formed the view that Adult A was not getting the support that he felt she deserved.

6.4 Adult Social Care

6.4.1 From a young age Adult B had difficulties with verbal and non-verbal communication. He had challenges with communication and social skills. He was assessed as needing support in various areas including decision making and managing his own behaviour.

6.4.2 In 2005 a complaint was made by a member of the public about Adult B performing an inappropriate sexual act at a local swimming pool. The matter was dealt by staff at the college he was attending at the time and no onward referrals were made. This was the first incident of sexualised behaviour and there were several others throughout the review period. The Overview Report highlights opportunities for relevant agencies to work with those who have children with Autism to understand the need to teach boundaries and lessons on the subject.

6.4.3 In November 2005 Adult C broke into the family home and assaulted Adult A. Adult A raised concerns that this may have an adverse effect on Adult B and as a result he began to attend a local care centre to provide respite for Adult A.

6.4.4 In November 2006 Adult B was assaulted by Adult E, at the day care centre, and Adult E was arrested. Adult E admitted a charge of assault.

6.4.5 Early in 2007 Adult A met with staff from the Community Team for People with Learning Disabilities (CTPLD) and it was agreed that they should find a residential placement for Adult B. In May 2007, Adult B moved into a local care home however Adult A was unhappy at the quality of service, and it was suggested that Adult B be moved to a different care home away from the area.

6.4.6 In February 2008 Adult B was voluntarily admitted to a hospital in Berkshire, one for those with learning disabilities and shortly afterwards he went into a residential care home on the south coast. This care home specialised in supporting those with Autism Spectrum Disorders (ASD) and learning disabilities. Adult B was resident there until 2012.

6.4.7 In January 2010, whilst living at the residential care home on the south coast, Adult B locked a female service user in his room and staff had to force entry, where they discovered the female unharmed. A subsequent search of the room discovered pictures of fully clothed children with semen on them. When confronted, Adult B damaged his games console.

6.4.8 In September 2012 Adult A removed Adult B from the care home. The Royal Borough of Windsor and Maidenhead resisted this action and began legal processes; however, these were not followed through. A capacity assessment took place regarding Adult B's ability to make decisions for himself and it was agreed that he was doing much better at home. Subsequent attempts at assessment, by the residential care home, were unsuccessful.

6.4.9 In September 2013 Adult B was referred, by his GP, for a medication review with the Consultant Psychiatrist, working with the CTPLD, due to his weight gain and erratic behaviour. The request had been made by Adult A and there is no reference to any consultation with Adult B. Subsequent appointments were offered but declined by Adult A.

6.4.10 In July 2015 an assessment was completed under the Mental Capacity Act (MCA), and it was decided that Adult B was not able to make his own decisions in relation to contact with his father.

6.4.11 In February 2016, whilst on a social event, arranged by the Berkshire Autistic Society, Adult B was seen touching himself inappropriately towards a female service user. The two were kept apart during subsequent activities.

6.4.12 In October 2016 the CTPLD manager completed an MCA assessment to consider Adult B's suitability to attend a local day care centre. The results were not recorded but Adult B began attending the day centre. In November, Adult A withdrew Adult B from attending and requested a change of social worker. The rationale for this is unknown.

6.5 <u>Berkshire Healthcare NHS Foundation Trust</u>

6.5.1 BHFT first engaged with the family in 2012 when Adult B returned home, from the south coast care home.

6.5.2 In 2013 Adult A requested a medication review and Adult B was referred to a consultant psychiatrist at the CTPLD, this review was never completed.

6.5.3 In September 2016, following a report by Adult C, the Community Mental Health Team (CMHT) street triage worker, along with the police, visited Adult A's home and a mental health assessment was completed on Adult A. During a follow-up visit the following day Adult A described caring for Adult B as stressful but was keen to scale back support.

6.6 Clinical Commissioning Group – GP Surgery

6.6.1 Adult A

There are issues recorded, which are outside of the review period worthy of note. In 1999 medical records show that Adult A attempted an overdose and was diagnosed with depression and mental illness.

6.6.2 Adult B

Adult B's medical history records that he was diagnosed with hyperactivity and autism in 1986 and this was further formally recorded in 2001 along with frequent seizures. The records further document that subsequent appointments to manage Adult B's other condition (epilepsy) were often cancelled by Adult A.

6.6.3 There were no records between 2008 – 2012 as Adult B was living in a residential care home on the south coast. On returning home, Adult A had consulted with the GP about Adult B's weight gain, and he was referred to a consultant psychiatrist.

6.6.4 Due to his conditions Adult B had been entered on to the surgery's Learning Disability Register and was invited to attend annual health checks. These were always declined by Adult A who told the surgery that she did not want him to have these checks ups.

6.7 Radian Housing

6.7.1 Radian had a number of contacts with Adult A, but the majority related to property maintenance and rent matters.

6.7.2 There were no issues identified regarding domestic abuse however between August and December 2015 there were various issues with a neighbour who was allegedly abusive to both Adult B and Adult C. Radian and the police both attempted to resolve the issues, including an offer of mediation which was declined by Adult A. Meetings took place involving Radian's Neighbourhood Officer, Adult B's social worker and Adult A. Adult A expressed concerns over the impact that these incidents were having on Adult B's emotional well-being. By December 2015 things appear to have calmed down and the matter was closed.

6.8 Thames Valley Police

6.8.1 During the reporting period there were 20+ reports to the police involving a variety of complaints, including assaults, harassments and family disputes. The source and focus of the engagements varied with family members making allegations against one another. Three of these reports directly involved Adult B, either as a victim or vulnerable adult. The review identified several incidents when Adult B's details were not recorded.

6.8.2 In September 2016 as part of Op. Fledge (a multi-agency project to support mental health workers visiting emergency crisis calls) a police officer and a mental health worker visited Adult A. She would not allow them beyond the hallway, and they were unable to see Adult B. She refused to take part in a full psychiatric assessment.

6.8.3 On the day of the homicide Adult B was found in the street by officers covered in blood and when taken home, the body of Adult A was found.

7. KEY ISSUES ARISING FROM THIS REVIEW

7.1 This review recognised that there was no recorded history of domestic abuse between Adult A and Adult B. The only documented act of aggression towards Adult A, ever recorded was on the night of her death. In 2013 Adult A disclosed that years previously Adult C had broken one of her ribs however this was never reported to an agency. It was during his police interview (as part of the homicide investigation) that it became apparent that it was Adult B's interest in a female he'd met at a social club and Adult A's attempts to help him understand that no relationship was ever going to start which caused him to fatally assault his mother[1] [2].

7.2 Sexualised Behaviour

There were several incidents recorded where Adult B carried out acts of sexualised behaviour which the review considers worthy of mention. These are recorded in Section 5.5.1 of the Overview Report.

People with an Autism Spectrum Condition (ASC) can have difficulty understanding others' body language, facial expressions, and tone of voice. 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 and those with ASC may easily misinterpret these and develop an unrealistic notion of how relationships develop.

[1] Research has shown that rejection, separation and failing mental health are all homicide 'triggers'.

[2] 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]

Children

It is crucial that when explaining sexual issues to children with ASC, they are taught clearly and calmly and in a way that they understand. 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.

Sometimes adults will allow a younger child with ASC to do something of a sexual nature because the adult feels uncomfortable addressing the issue. This will not help the child for the future. 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. 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[3].

Adulthood

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.

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.

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.

Advice is provided by various organisations[4] to aid those supporting individuals demonstrating such challenging behaviours for example:

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

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

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.

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.

Adult B had demonstrated sexualised behaviour for many years and, despite being recorded as such, support in helping Adult B understand acceptable behaviour was not apparent and this included support for Adult A. The nature of Adult B's condition means that it was possible he would be normalising these behaviours unless taught otherwise.

7.3 The combined chronology quickly identified that there were regular issues of domestic arguments, harassment and threats between family members, with Adult A the most regular victim. This demonstrated concerns over abuse, within the family taking place and the impact that it had on individuals as well as the whole family. Whilst there are no formal recorded incidents or investigations of Adult B perpetrating other domestic

abuse incidents, there was some information to indicate that Adult A was the victim of a wider pattern of domestic abuse.

7.4 Adult A's method of parenting was to take very close care of Adult B and accept support as she deemed it appropriate. During the early part of the review, it was clear that Adult B's mental capacity was rarely assessed despite many decisions being made which affected him directly and whilst this improved later on it remained the case that Adult A was the dominant decision maker. The question of the role of carer has been recognised and, that there is a need for a suitable assessment process in order that those in Adult A's position have their physical and emotional well-being suitably supported.

7.5 <u>What is mental capacity and when might it need to be assessed?</u>
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.

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 also those with full time carer's responsibilities.

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 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.

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.

During the review it was clear that many agency interactions, particularly with the victim, would have been enhanced with more intrusion and better Professional Curiosity. For example, there were visits to Adult A's home which could have been crucial in exploring the family dynamic, equally more regular information sharing, when referring from one agency to another, may have better equipped practitioners going forward. In addition to these two key issues there is the matter of record keeping as there are several areas in which records were incomplete or lacked detail. This has been recognised as an opportunity to improve service delivery.

7.6 MARAC and Information Sharing

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.

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 in May 2009. However, there was clearly a need for a separate process to deal with cases that fall outside the MARAC framework.

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.

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 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. The work of this meeting is crucial in managing risks and identifying themes of abuse within particular families.

7.7 Mental health was a thread throughout this review, and it was obvious that Adult A, Adult E and the three son's each had their own challenges. The findings of the criminal trial indicate that there was direct link between Adult A's death and mental health. The subject has a role to play in almost every engagement during the review period. There is nothing to suggest that alcohol or drugs were factors here and so the review seeks to highlight to link between mental health and domestic abuse.

7.8 Following the conclusion of a DHR there is an opportunity for agencies to consider the local response to domestic violence and abuse in light of the learning and recommendations. This is true for agencies both individually and collectively. The Review Panel hopes that this work will be underpinned by a recognition that the response to domestic violence and abuse is a shared responsibility as it is everyone's business to make the future safer for others.

8. CONCLUSIONS

8.1 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.

8.2 For those close to Adult A the tragedy is made all the more difficult as the perpetrator was her son, Adult B. It is no secret that each of Adult A's sons had mental health needs and that Adult A had done everything in her power to protect and support them. 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.

8.3 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.

8.4 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.

8.5 These opportunities 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 the Domestic Abuse Stalking Harassment and Honour Based Abuse (DASH) Risk Identification Checklist 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.

8.6 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 for itself. 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.

8.7 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.

8.8 In approaching learning and recommendations, 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.

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

9. LESSONS TO BE LEARNED

9.1 The analysis has identified a number of lessons which should be learned in order to improve the services provided to the community within the Royal Borough of Windsor and Maidenhead CSP. These learning points have led to a series of recommendations which the Review Panel converted into an action plan.

9.2 Throughout Adult B's life Adult A had dedicated herself to caring for him. She had received a broad and regular array of agency services provided to her and had been confident in accepting and declining it as she saw fit. Adult B had been encouraged to take a number of medical assessments and attend various residential and day care venues. Adult A had taken responsibility for deciding whether or not he should attend such assessments and day care centres and also acted on his behalf when deciding when the time was right to leave residential facilities. This review can find no record of Adult A having had a formal Carer's Assessment. The overview identifies two points of learning with regards to parental responsibility/carers assessment and patient consultation.

9.3 Following reports, from Adult C, that Adult A was suffering a mental breakdown the Crisis Resolution and Home Treatment Team (CRHTT) visited Adult A twice (on one occasion with a police officer) to discuss details with her and complete a Mental Health Assessment. However, on both occasions Adult A was reluctant to engage and on neither occasion were the professionals able to see Adult B, despite knowing that he was in the house.

9.4 Sec 42 of the Care Act places certain expectations upon local authorities to make enquiries if they believe that a person is at risk of abuse or neglect, and this requires a multi-agency response and the potential for a formal protection plan to be prepared. A learning point is raised in the Overview Report with regards to professional curiosity.

9.5 Following the arrest and subsequent investigation of Adult E in November 2006 a 'Domestic Violence Risk Assessment' was completed and the risk presented by Adult E to Adult B graded as medium. There is a similar incident, reported in May 2008, of Adult E assaulting Adult A, the risk assessment was also graded as medium. However, the chair takes the view that this matter may have been treated as High risk and therefore information could have been shared more easily via the MARAC process. This is raised as a learning point in the Overview Report. There were several other reports of threats and violence directed towards the victim and perpetrator, by other members of the immediate family. There appears to be a general lack of awareness regarding interfamilial abuse and as a result a learning point on this subject was also raised.

9.6 There were a number of reports involving calls to the police (in 2011, 2012 & 2013) and other incidents at the care homes. There was a lack of risk assessment records

being created and equally poor record keeping generally. These details generated learning points on both subjects.

9.7 In September 2016 the family home was visited as part of Op. Fledge[5]. Adult A was reluctant to allow the health worker and police officer to have access to see Adult B and this appears to have been accepted. A learning point was raised and seeks to remind mental health professionals and police of the opportunities and responsibilities when presented with barriers similar to this, for example Sec 42 of the Care Act and also Sec 135 of the Mental Health Act.

9.8 There were two incidents in September 2016 firstly where Adult A was encouraged, by her GP to have a mental health assessment, which she declined. Secondly where Adult A also declined the offer of an annual health check for Adult B. These incidents may have been a trigger to other matters, relating to domestic abuse, and therefore it would have been advantageous to share this information with agencies already working with the family. A learning point has been raised to emphasise this.

9.9 The support for Adult B was led by the Adult Social Care (ASC) team and in particular the Community Team for People with Learning Difficulties (CTPLD) and had been known to them from 2005. The records kept by this department were often limited and whilst managers in this department have reassured the Review Panel that things have improved significantly, and the Review Panel feels that the Community Safety Partnership should reassure itself that their expectations are being reached.

9.10 The review recognised that there were several incidents of sexualised behaviour demonstrated by Adult B, whist out public. The are many academic studies[6] which recognise that teaching people with Autistic Spectrum Syndrome (ASD) about sexual issues can be a complex task. Those with ASD need support to understand what is (and is not) appropriate behaviour as they are less likely to pick things up intuitively. A learning point has been raised that all agencies working with individuals and families that have ASD 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.

9.11 The review also identified areas for improvement with regards to the Multi-Agency Risk Management Framework and Mental Capacity Assessment. The Review Panel has

[5] 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.

[6] https://www.nice.org.uk/guidance/ng55/documents/draft-guideline

been reassured that these issues have been addressed and improvements made. Two learning points and recommendations have been raised to ensure that this is the case.

10. RECOMMENDATIONS

10.1 IMR Recommendations (single agency)

The following single agency recommendations were made by agencies in their IMR's:

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.

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.

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.

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.

10.2 Overview Report Recommendations

These recommendations should be acted upon through the development of an action plan, with progress reported to the RBWM Community Safety Partnership (CSP) and the Safeguarding Adults Board (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

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.