Overview Report:

Domestic Homicide Review in respect of the death of Peter in February 2020

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COMMISSIONED BY SOUTHAMPTON SAFE CITY PARTNERSHIP

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Foreword by the Chair of the Review on behalf of the Panel

As the Chair of this Domestic Homicide Review Panel, I would wish to add my deepest sympathies along with those of the Panel to Peter’s family. His loved ones described Peter as a much-loved father, brother, and grandfather with a “contagious personality” who believed in “living a vibrant life full of laughter.”

Domestic Homicide Reviews serve a number of key purposes, these include learning how local professionals and organisations can work more effectively individually and together to safeguard victims of Domestic Abuse, thereby helping to prevent Domestic Abuse, violence, and homicides. We hope that this review has honoured Peter’s life.

Jan Pickles OBE Chair and Author

1. Background

1.1. The circumstances that led to this review.

In February 2020 Peter was killed by his son Edward at the flat they shared in Southampton. Following Edward's arrest this case was referred to the Southampton Safe City Partnership[1] by Hampshire Constabulary for consideration of a Domestic Homicide Review (DHR). A decision was taken by Southampton Safe City Partnership to instigate a DHR in March 2020 and the Coroner was informed.

The review will consider agencies contact/involvement with Peter and his son Edward and look back to understand the position Peter found himself in. The key purpose for undertaking DHRs is to enable lessons to be learned from homicides where a person is killed because 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 needs to change to reduce the risk of such tragedies happening in the future.

1.2 Timescales

The Review Panel was established in September 2020 and the Review was concluded in June 2022. This Review was delayed by the COVID-19 pandemic as agencies required a longer period to complete their Individual Management Reports (IMRs). The Serious Incident report commissioned by Southern NHS Trust was shared with the panel in July 2021.The Panel were informed in October 2021 that Public Health England were to review Peter's case and so paused. In May 2022 the Panel learnt that this review has not yet started and so concluded the DHR to avoid further delay.

1.3 Confidentiality

The findings of this review are confidential. Information is available only to participating officers/professionals and their line managers. In order to protect the identity of the victim the family were asked to choose pseudonyms.

1.4 Equality and Diversity

The review gave due consideration to each of the protected characteristics under Section 149 of the Equality Act 2010. Peter (male) was 70 years old at the time of his death in February 2020 he identified as White British, heterosexual and had no

[1] The Safe City Partnership is a statutory partnership that brings together organisations and commissioners with responsibility for keeping people safe.

diagnosed disabilities. Peter was known to be reluctant to access services for himself or his son by his family.

In terms of Edward (male) and the Protected Characteristics within the Equality Act 2010, he identifies as White British, heterosexual and was 28 years old at the time of the Manslaughter and was receiving treatment for his mental health.

Despite being an infrequent crime, parental homicide has been associated with schizophrenia spectrum disorders in adult perpetrators and a history of child abuse and family violence in adolescent perpetrators. Among severe psychiatric disorders there is initial evidence that delusional misidentification might also play a role in patricide.[2] The family have stated that Edward had witnessed domestic abuse in his parents' relationship as a child and at the time he killed his father believed him to be in a sexual relationship with his girlfriend.

1.5 Methodology

The Southampton Safe City Partnership agreed that the criteria for a DHR was met in March 2020 and commissioned Jan Pickles OBE to undertake the review. The initial scoping identified that nine agencies held relevant information. This report is based on the IMR's commissioned from professionals who are independent from any involvement with the victim, his family, or the perpetrator. The IMR authors have indicated whether there is confidence in the standard of practice and made recommendations to the Panel. All IMR authors were chosen as they had no direct or indirect contact with the staff involved with the victim, perpetrator, or wider family.

The IMR's have been signed off by a responsible officer in each organisation. The IMRs from all agencies were integrated into an overarching chronology of events that led to death of Peter.

1.6 Terms of Reference (see Appendix 2 for Terms of Reference in full)

This Domestic Homicide Review (DHR) was commissioned by the Southampton Safe City Partnership following the homicide of Peter in February 2020.

The key purpose of undertaking domestic homicide reviews (DHR) is to identify the lessons to be learnt from homicides in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse, or neglect by –

[2] Patricide and overkill: a review of the literature S Trotta, G Mandarelli & D Ferorelli & B Solarino Forensic Science, Medicine and Pathology (2021) 17:271–278
Patricide_and_overkill_a_review_of_the_literature_.pdf

(a) a person to whom he was related or with whom he was or had been in an intimate personal relationship, or

(b) a member of the same household as himself

Domestic homicide reviews are not inquiries into how the victim died or who is culpable. In order for lessons to be learnt as widely and thoroughly as possible, professionals need to be able to understand fully what happened in each case, and most importantly, what needs to change in order to reduce the risk of such tragedies happening in the future.

The victim is understood to be the father of the perpetrator.

The purpose of the review is to:

- Establish the facts that led to the incident in February 2020 and whether there are any lessons to be learned from the case about the way in which professionals and agencies worked together to safeguard the family.
- Identify what those lessons are, how they will be acted upon and what is expected to change as a result.
- Apply these lessons to service responses including changes to policies and procedures as appropriate.
- Prevent domestic violence and abuse homicide and improve service responses for all domestic violence and abuse victims and their children through improved intra and inter-agency working.
- Establish the facts that led to the incident and whether there are any lessons to be learned from the case about the way in which local professionals and agencies worked together to support or manage the perpetrator.

Domestic Homicide Reviews are not inquiries into how the victim died or who is culpable. That is a matter for coroners and criminal courts.

Scope of the review

- Consider the period from Feb 2016 to February 2020 subject to any information emerging that prompts a review of any earlier incidents or events that are relevant.
- Request Individual Management Reviews by each of the agencies defined in Section 9 of the Act and invite responses from any other relevant agencies or individuals identified through the process of the review.
- Seek the involvement of the family, employers, neighbours & friends to provide a robust analysis of the events.

- Take account of the coroners' inquest in terms of timing and contact with the family.
- Produce a report which summarises the chronology of the events, including the actions of involved agencies, analysis and comments on the actions taken and makes any required recommendations regarding safeguarding of families and children where domestic abuse is a feature.
- Aim to produce the report within six months after completion of the criminal proceedings, responding sensitively to the concerns of the family, particularly in relation to the inquest process, the individual management reviews being completed and the potential for identifying matters which may require further review.

In addition, the following areas will be addressed in the Individual Management Reviews and the Overview Report:

- Was the victim known to domestic abuse services, was the incident a one off or were there any warning signs. Could more be done to raise awareness of services available to victims of domestic abuse?
- Was the perpetrator known to domestic abuse services, was the incident a one off or were there any warning signs.
- Were there any barriers experienced by the victim or family, friends and colleagues in reporting the abuse.
- Where there any opportunities for professionals to routinely enquire as to any domestic abuse experienced by the victim that were missed?
- Are there any training or awareness raising requirements that are necessary to ensure a greater knowledge and understanding of the services available?
- Consider any equality and diversity issues that appear pertinent to the victim, and perpetrator.
- Was the alleged perpetrator known to have a history of DA, if so, what support was offered to the perpetrator?
- Were staff working with the alleged perpetrator confident around what service provision is available around DA locally?

1.7 Involvement of Peter's family

Following the initial DHR Panel meeting in September 2020 the Chair contacted the Victim Support Homicide Team who were already providing support to Peter's family. They had received leaflets and information on the DHR process. The Chair spoke initially to Peter's son and his ex-partner the mother of his two sons. At that time, they were preoccupied dealing with the Serious Incident Report (see paragraph 2.5) and we agreed to speak after that was finalised. At the beginning of 2021, the Chair continued to communicate with both and had virtual meetings with them separately. In June 2021 his son attended the DHR Panel and provided a moving description of the impact this tragedy had on the entire family he was able to challenge and seek

assurance. The Panel's view is that this Review has benefitted from his involvement. In August 2021 once the Covid restrictions were lifted, the Chair met face to face with Edward's mother. Their views are contained in this report and draft recommendations were discussed with his brother in October 2021. At this point the family and Panel felt it appropriate to pause the review to allow Public Health England to conduct their Review. The final draft of this DHR was shared with Peter's son and ex-partner in June 2022, and their comments included.

Edward was in a relationship with a girlfriend in the year prior to Peter's death and an offer was made to her via Edward's mother who she remains in regular contact with to participate in this review, but she chose not to. In her Victim Impact Statement his then girlfriend said she had subsequently suffered from post-traumatic stress disorder because of this experience and the Panel agreed not pursue further contact whilst the offer remained open to her throughout this process.

The next of kin for the family was identified as his older son. He gave permission for the panel to view Peter's' medical records as part of the review. He also felt able to meet with the entire Panel in June 2021 sharing with the Review the harrowing everyday impact of living with a loved one with mental health issues prior to this tragedy. The Panel asked that if he felt able a video of him sharing the impact on the family would be a powerful training tool for Southampton.

1.8 Involvement of the Perpetrator

Edward appeared at Winchester Crown Court in September 2020, he was sentenced to a Hospital Order with restrictions under Section 37/41 of the Mental Health Act 1983 without limitation of time and has also been allocated under the Multi Agency Public Protection Arrangements (MAPPA) as a Category 2 MAPPA nominal[3]. Following Edward's detention under the Mental Health Act the Chair wrote, with the permission of his family, to his Consultant at the Hospital where he was detained and requested their permission to speak with him. Staff on the Unit arranged for a conversation with Edward in February 2021 when it was assessed by them to be helpful and not detrimental for him. Edward expressed great remorse and regret at the death of his father. He believes that it would have been beneficial that a strategy to help him when he was ill should have been agreed when he was well between himself, the agencies involved and his family. Edward is in regular contact (despite

[3] MAPPA is the process through which the police, probation and prison services work together with other agencies to assess and manage violent and sexual offenders to protect the public from harm.
Level 2 - Active multi agency management
The risk management plans for these offenders require the active involvement of several agencies via regular MAPP meetings.

the Covid-19 visiting restrictions) with his mother and brother. All recognise that they as a family are struggling to live with this tragedy for both Peter and Edward.

2. Membership of the Review Panel

The following agencies were invited to be part of the DHR Panel. All members were representatives of their respective organisations and had had no direct or line management responsibility for services provided to Edward and his family. The organisations and members are stated as they were at the time the review was commissioned. It is acknowledged that some organisations have undergone change since then.

Agency Representative	Name	Role
Independent Chair	Jan Pickles	Chair and Author
Southern Health NHS Foundation Trust	Adam Cox	Clinical Director for Southampton Division & Crisis Team consultant
Southern Health NHS Foundation Trust	Liz Hall	Head of Patient Services
Southern Health NHS Foundation Trust	Caz Maclean	Associate Director of Safeguarding
Southern Health NHS Foundation Trust	Clare Fulker	Specialist Safeguarding Practitioner
Solent NHS Trust	Fiona Holder Karen Davies	Head of Safeguarding Lead Nurse for Adult Safeguarding for Solent NHS Trust
Southampton City Council	Karen Marsh	DSA Manager- IDVA Service Manager
University Hospital Southampton NHS Foundation Trust	Ann Rodwell	Adult Safeguarding Nurse Specialist
National Probation Service	Jenny Mckie	Attended the inaugural meeting then stood down by the panel

Southampton City Council	Sandra Jerrim	Senior Commissioner Integrated Commissioning Service
Southampton City Council	Martin Buckmaster	Deputy Manager Homelessness
Southampton City Council	Amy Bradley	Approved Mental Health Professional Team Manager
Southampton CCG	Siobhan West Lindsay Voss	Designated Nurse for Safeguarding
Hampton Trust	Chantal Hughes	CEO
Southampton City Council	Eric Smith	Adult Safeguarding Team Manager
Southampton City Council	Kerry Owens	Assistant Domestic & Sexual Abuse Co-ordinator Adults Housing & Communities
Hampshire Constabulary	Grace Mason Bryan Carter	Serious Case Reviewer

The Senior Investigating Officer, a Detective Chief Inspector from Hampshire Constabulary attended the Panel meeting in September 2020 to brief the panel on the Police investigation.

2.1 Review Panel Meetings

The Panel met on eight occasions in September and December 2020 and January, April, May July, September 2021 and January 2022 to agree and review the IMRs and then to comment on successive drafts of the review. The review process was paused whilst it awaited the Serious Incident report. The Panel paused in October 2021 to allow the Public Health England review. All meetings were held virtually due to the Covid-19 travel restrictions.

2.2 Scoping and Individual Management Reports

Scoping requests were made to 18 agencies:

1. Southampton City CCG
2. Solent NHS Trust
3. Hampshire Constabulary
4. University Hospital Southampton NHS Foundation Trust

5. Southampton City Council – Housing & Homelessness
6. Southampton City Council – Environmental Health
7. Southampton City Council – IDVA
8. Southampton City Council – Adult Social Care
9. Southern Health NHS Foundation Trust – Mental Health
10. Victim Support
11. Yellow Door
12. Aurora New Dawn
13. Hampshire Liaison Diversion Service
14. South Central Ambulance Service
15. Vivid Housing
16. National Probation Service
17. The Hampton Trust - Domestic Abuse provider
18. CGL - Substance Abuse provider

From this the Panel identified seven agencies with relevant information who were then asked to provide a full IMR:

1. Solent NHS Trust
2. Southampton City Council – Adult Social Care
3. Southern Health NHS Foundation Trust – Mental Health
4. Southampton City Council -Housing
5. Hampshire Constabulary
6. Southampton City CCG
7. University Hospital Southampton NHS Foundation Trust

2.3 Chair and Author of the Review

Jan Pickles was appointed as author of the DHR and author of this report in October 2020. She is an experienced author of DHRs and Safeguarding Reviews for adults and children. She is a qualified and registered social worker with over forty years' experience of working with Perpetrators and victims of Domestic Abuse, coercive control, and sexual violence, both operationally and in a strategic capacity. In 2004, she received an OBE for services to victims of Domestic Abuse for the development of both the Multi Agency Risk Assessment Conference (MARAC) model and for development of the role of Independent Domestic Violence Advisers (IDVAs). In 2010, she received the First Minister of Wales's Recognition Award for the establishment of services for victims of sexual violence. In her career, she has held roles as a Probation Officer, Social Worker, Social Work Manager, Assistant Police and Crime Commissioner and as a Ministerial Adviser. Currently an Independent Board member on a Welsh NHS Trust and a member of the National Independent Safeguarding Board for Wales. She has completed the Home Office training for chairs and authors of Domestic Homicide Reviews in 2013.

Jan Pickles is not currently employed by any of the statutory agencies involved in the review (as identified in section 9 of the Act) and have had no previous involvement or

contact with the family or any of the other parties involved in the events under review.

2.4 Parallel Reviews

The Southampton Safe City Partnership informed the Coroner and the relevant agencies in September 2020 that this DHR was to take place. A Serious Incident review was commissioned by the Southern Health Foundation NHS Trust's Clinical Director for the Southampton Division. At the request of the family an investigator independent of Southern Health Foundation NHS Trust was appointed. In response to the families view the Serious Incident Investigating Officer commissioned to undertake this investigation was employee of the Solent NHS Trust. The Serious Incident review was shared with the panel in July 2021. In September 2021, the Panel were informed that NHS England Improvement Service were to also undertake a review and the DHR paused awaiting the outcome of this. However, in May 2022 the Chair learnt that this process was yet to start and therefore this review process was concluded.

2.5 Dissemination

Recipients who received copies of this report before publication are the panel members identified in 2.

Publish the findings in accordance with the Home Office Guidance to enable the lessons learned to be shared in the wider arena. The full DHR was shared with Peter's family in final draft and their comments were welcomed and incorporated into the final document prior to being presented to the commissioning authority, Southampton Safe City Partnership. Once agreed by them the final draft will be sent to the Home Office for quality assurance and then published in such a way that will respect the family's privacy.

A copy of the executive summary will be sent to the Consultant responsible for Edward's care in Hospital and if deemed appropriate it will be shared with him with those caring for him providing support at that time. Should Edward wish and those responsible for his care, approve arrangements will be made to meet with the Chair and author to discuss the report.

3. Background Information

3.1 In February 2020 Peter was killed by his son Edward at the flat that they both shared in Southampton. Edward pleaded Guilty to Manslaughter on the grounds of diminished responsibility and was sentenced at Southampton Crown Court in September 2020. Edward received an Indefinite Hospital Order. Peter was strangled by his son using his hands and a phone charger cable.

3.2 At the time of the Manslaughter Edward was living with his father in his flat. In the year before Peter's death Edward was in a relationship with a young woman who worked alongside his mother and brother to support him. Previously Edward had lived with his mother and then his girlfriend. He had lived with his father at various times since September 2018. He had also stayed for a time with a friend, and had been street homeless, prior to the homicide. Edward at times had lived with his mother, at her flat near to Edward's father. Edward's brother had also lived at that property with his mother. His mother describes herself and older son as "living in emergency mode for several years because of Edward's behaviour."

4. Chronology

4.1 Peter was aged seventy at the time of his death in February 2020. He was the father of Edward and his older brother; he had six children from a previous relationship with whom we believe he had no contact. Peter had separated from Edward's mother when Edward was about five years old. Peter remained in Southampton after the separation but saw little of his sons. He came back into their lives when they were teenagers. Peter had been a long-distance lorry driver prior to his retirement, he was known to experience occupational related health problems in terms of his mobility and joint pain. There is little reference to Peter in the agency records and both his ex-partner and son describe him as someone who did not seek help from services. It appears he was not known to the statutory or voluntary services within Southampton. Both his older son and ex-partner described Peter as a confident man who could manage conflict and was unlikely to ask for help.

4.2 Edward experienced behavioural difficulties in school, which on reflection his mother feels may have been related to his later mental health difficulties. Edward was described by his mother and brother as a caring child with a big heart. He was never violent, and who as an adult when well was always polite and kind. We do know that as Edward's moods and behaviour deteriorated his father became more involved in supporting him, providing, and helping him to find accommodation, providing advice and occasionally contacting agencies trying to get help for him. The Panel is aware that relations between Edward and his father were at times strained and difficult. Edward moved between his parents, and when close with one was distant with the other. It is our view that under the pressure of the events that led to this DHR it is likely this strain increased in response to Edward's delusional beliefs that his father was having an affair with his girlfriend. It is of note that the Southern Health NHS Foundation Trust IMR describes Edward's mother marrying again after the separation from Peter and that 'this was a difficult relationship which involved Domestic Abuse and Edward and his brother were witnesses to this in their teenage years.' Despite the sometimes-strained relationship with their father both loved him, and Edward remains bereft that he killed him.

4.3 The focus in this chronology will now shift to Edward and those who had a personal and professional relationship with him to better help us to understand the circumstances that led to his manslaughter of his father.

4.4 There is little of note in the records made available to the Panel regarding Edward until he became involved in low level crime in the area aged approximately fourteen years old. The IMR for Hampshire Constabulary report that "Edward has been known to Hampshire Constabulary since 2005 when he was arrested for criminal damage. Records reflect that between 2005 and 2010

he came into police contact sporadically for low level offending; theft and damage and on occasion more serious offending such as burglary. During the period 2011-2014 he was linked to class B drug use and was arrested for burglary. From 2016 onwards Police contact with Edward was primarily due to behaviour linked to his mental health issues described below.

4.5 The first significant event that is related to this DHR was in July 2016 when Edward was on holiday in Ibiza with friends and he experienced what was later identified as a ‘psychotic episode’ in which he became paranoid, believing that people were following him. It is reported that Edward climbed onto the hotel roof he was staying at to ‘escape’ from them. He later climbed down from the roof and was kept in hospital for a short period. It seems the trigger for this episode was his use of methylenedioxymethamphetamine (MDMA or ecstasy) and cannabis. These symptoms continued on his return to the UK.

4.6 In mid-August 2016 Police were called after Edward had punched a hole in the ceiling of his father’s flat and climbed onto the roof of the fifth floor flat that he shared with him. Edward had earlier attended hospital that day due to symptoms related to his declining mental health. It was recorded that Edward had a knife, was erratic and under the influence of drugs. This was a serious incident that lasted for 24 hours involving a range of emergency services attempting to coax Edward down. The IMR from Hampshire Constabulary states that he refused to engage with workers attending and that after approximately 24 hours on the roof he jumped, sustaining a broken leg and head injury. This suggests a determination and a willingness to either take or risk his life. The jump could have been fatal; it was estimated that he jumped from a height of thirty to forty feet. It is not known if the motive was suicide, or was a response to stress, panic, anxiety, or the influence of drugs. An on- call Psychiatrist attending that incident informed the Police attending that; “she was told Edward ran off the roof, swallow dived and flipped in the air landing on his back. This is confirmation of significant intent to end his life.” A CA12 adult at risk notification for partner agencies, was not completed by attending Police Officers, the IMR author of Hampshire Constabulary stated this was because there were other services in attendance at the scene. The Hampshire Constabulary IMR author states that at this time there was not a consistent understanding amongst Police when attending an incident where other services were in attendance as to whether a notification (form CA12) needed to be sent by the Police. This has since been clarified.

4.7 A similar incident was responded to by emergency services five weeks later at Edward’s mother’s address in mid-September 2016 in which Edward climbed onto his mother’s shed roof holding a knife to his chest, threatening to kill or harm himself. This event began at 8am on that day and took 20 hours to resolve, involving a number of emergency services through the day. Eventually Edward

was taken to Hospital and was detained under Section 2 of the Mental Health Act following assessment in which he was identified as ‘High Risk’ to self and experiencing a ‘Psychotic episode’. It was agreed between the Duty Mental Health Social Worker and the Adult Safeguarding Duty Social Worker that Edward did not meet the threshold for a Section 42[4] triage but did have care and support needs that could be met by Mental Health Services, and a referral was made to them.

4.8 The event above was preceded by two incidents the day before in mid-September 2016. The first began outside of Southampton Central Police Station, the other at Southampton A&E Unit. Edward had been taken to the Police station by his mother and brother due to their concerns about his deteriorating mental health and behaviour. He was seen at the Police Station and Mental Health services were contacted by them. Due to the length of time, it took for a response and the distress the family were experiencing Edward’s mother and brother themselves took Edward to the A&E Unit. Edward continued struggling and arguing with his mother and brother. It was seen that he had a knife, and it was thought he was attempting to kill or harm himself. Edward was able to be managed and taken home where he later received a visit from the Adult Mental Health Team, who felt he should remain at home. Both Edward’s mother and brother felt he needed to be admitted to Hospital. The following morning Edward as described above climbed onto the roof of the shed at his mother’s house and Emergency Services were alerted. Edward was detained under Section 2 of the Mental Health Act at a Solent NHS facility. During this admission he received care from Solent’s Psychiatric Intensive Care Unit, (PICU), and Solent’s Acute Mental Health Unit, (AMH). He received treatment for delusional thoughts and self-harm.

4.9 Edward was discharged from the Solent NHS facility following treatment to his mother’s address at the end of September 2016. He was diagnosed with a Psychotic Disorder. Care was transferred to the Adult Mental Health Team (AMHT) and Early Intervention Psychosis (EIP) two weeks later in mid-October 2016. Edward’s behaviour from the first incident on holiday onwards stemmed from his belief that he

[4] 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.’ Safeguarding adults’ is the name given to the multi-agency response used to protect adults with care and support needs from abuse and neglect. 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.

had witnessed a violent incident- whether a murder or stabbing is not clear in 2015 and that he felt he was at risk of being murdered because of this.

4.10 Edward was offered several rehabilitative community activities to aid his recovery, but records indicate he declined most support offered in this period, stating he preferred to find employment or his own activities. It appears that he moved between both his parents' accommodation in this time, in response to the state of his relationships with them. On a Home Visit in early January 2017 by the Mental Health Team (CMHT) Edward's mother disclosed details of Edward believing he had witnessed a stabbing, but Edward refused to talk about this experience and the reasons for his paranoia. In mid-February 2017, Edward's mother disclosed her concerns at his deterioration, outbursts of anger and aggression and non-compliance with medication. Edward's mother stated she was 'intimidated' by him, expressing her fear of him if he should find out she had contacted the Mental Health Team. She also disclosed Edward's drug use and that he carried a knife. He was assessed at home in mid-February 2017, the Southern Health NHS Foundation Trust chronology shows that the assessors were aware of the threats he had been making and non-compliance with both support and medication and that they attempted to negotiate his re- engagement with those services. A Mental Health Act (MHA 1983), assessment was undertaken, and he was assessed as well enough to remain at home.

4.11 In this period until the next serious incident described below, Edward's response to support offered was poor, missing appointments, non-compliant with medication, workers on a home visit by EIP in early March 2017 suspected him to be smoking cannabis and drinking alcohol, these were known potential risk factors given his diagnosis. Consideration was given to discharging Edward by the EIP, but this was overtaken by a subsequent serious incident.

4.12 The next significant event noted was at the end of April 2017, when Police were called to Edward's mother's home due to a disturbance. A CA 12 was submitted by Hampshire Constabulary to the MASH, but these are not routinely shared with Health agencies. Both Edward and both his parents were in the flat. Edward's mother had told him to leave her property and had had the door locks changed. It was stated Edward had threatened to 'burn the flat down.' This incident occurred following a deterioration in Edward's mental health in recent weeks with which his mother was unable to cope, and that he was verbally abusive. The Police IMR records that the attending officer completed a Domestic Abuse Stalking and

Honour [5](DASH) risk assessment and identified the risk as 'Medium.' The purpose of the DASH risk checklist is to give a consistent and simple tool for practitioners who work with adult victims of domestic abuse to help them identify those who are at high risk of harm. The chair of the Panel has spoken directly with Edward's mother who stated it was her recollection that she was not spoken with at any time in terms of the incident, not spoken to alone and was not aware that a DASH had been completed, and if it had it was not with her knowledge. She, and her older son were not aware that this incident was domestic abuse at the time. Hampshire Constabulary policy is that all victims should be spoken to on their own.

4.13 At the end of May 2017, Hampshire Constabulary were called to a disturbance at Peter's flat, Edward's father. Edward was armed with a knife and a piece of broken glass and was threatening his father and brother. When Officers arrived, Edward attempted to throw himself out of the window. He was caught hanging out of the window and was seen cutting at his neck and arms with the knife. Edward was restrained and made safe. Peter was offered added security for his protection which he declined as he knew Edward would be admitted to hospital. The Hampshire Constabulary IMR states he was assessed as 'Medium Risk' using the DASH assessment tool at the scene despite his use of weapons and his known use of drugs. Hampshire Constabulary records state that "The level of harm he (Edward) was prepared to do to himself was known to be at the higher risk end of self-harm" It was also noted that the parents may minimise the risk they themselves are at stating, "Whilst he (Edward) largely made threats to harm himself…his parents may have tended to minimise the impact on them and in the original call log it states he was threatening his Father and Brother with broken glass". Edward was later admitted to Hawthorns Ward, Parklands Hospital, Basingstoke under Section 3 Mental Health Act, a Southern Health facility. On admission it was recorded that he had "been hearing voices, messages from the TV, carrying knives to protect himself, has been using cannabis daily." He said he had not slept in four days.

4.14 The day after admission to the Southern Health Hospital Edward assaulted a member of staff on the ward, punching him to the face. The staff member required medical treatment as a result. Edward was transferred to the Orchards a Solent Health facility. Edward received care from Solent's Psychiatric Intensive Care Unit,

[5] The Domestic Abuse, Stalking and Honour Based Violence (DASH) form is a standardized risk assessment implemented across most UK police forces. It is intended to facilitate an officer's structured professional judgment about the risk a victim faces of serious harm at the hand of their abuser.

(PICU), and Solent's Acute Mental Health Unit, (AMH). He received treatment for delusional thoughts and self-harm.

4.15 The Serious Incident review commissioned by Southern NHS Trust and undertaken by Solent NHS states that Edward asked the Care Worker if he had a knife. The Care Worker responded by pointing to his keys, Edward then punched him to the side of his face, causing swelling. Edward was not charged with this assault, partly due to the victim at first declining to prosecute, though later changing his mind. Numerous times within this occurrence the Police Resolution Centre[6] staff stipulated that they needed to know whether Edward had 'fluctuating capacity.' They felt that if he did it would be unlikely to proceed to prosecution. They were corrected of this view at the time it was expressed. (Hampshire Constabulary and partners now have implemented Operation Cavell to ensure assaults on Emergency workers are dealt with robustly and it is resourced with 4 Inspectors who review the mental health elements of such cases to ensure all correct processes are followed and recognise that a lack of capacity is not a barrier to seeking a prosecution).

4.16 Edward was discharged in mid July 2017 from Hospital. Edward had accepted 'Depot' injections to reduce the symptoms of paranoia only due to his being sectioned and said he would refuse once he was discharged, which he did. This reluctance and refusal to comply is a recurring theme in his treatment. Edward believed his fear to be a response to a real threat and not paranoia. Edward and Peter had agreed on discharge that he would move into his father's flat and live with him. Edward's mother did not want him to go, believing he would smoke cannabis freely there, presumably with his father's consent. Southern Health NHS Foundation Trust records, who were visiting him, indicate that was where he was staying after discharge. Edward's response to discharge was mixed; a consultation in early October 2017 felt him to be displaying signs of paranoia, there was evidence of cannabis use and non-compliance with his medication and Treatment Plan. Prior to that the CMHT workers found that he varied in terms of his moods, that he identified problems with sleeping and paranoia but also had feelings of optimism.

4.17 From July 2017 to late March 2018 there were numerous contacts between Edward and the Early Intervention in Psychiatry Team (EIP Team) from Southern Health NHS Foundation Trust's Mental Health Service, and others involved in

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[6] The Resolution Centre is a dept. made up of staff and officers – they are tasked with resolving low risk and low harm crimes and non-crime occurrences.

Edward's medical care. There is a pattern to these contacts, which were mostly Home Visits. Edward in large part remained living with his father. His smoking cannabis and his intrusive thoughts, anxiety and paranoia continued to be a concern to medical staff. His compliance with the medical oversight he was subject to again became reluctant and he began asking for a discharge from EIP care. His father was reported to be positive about his son's progress. His brother shared that his father believed he and Edward could manage these issues by themselves and Peter was actively discouraging interventions. In late March 2018 Edward "discharged himself against medical advice". He was known to be non-concordant with his medication at the time. The EIP felt they had insufficient grounds to contest the application. This meant he was no longer receiving treatment of any kind.

4.18 At the end of May 2018 Edward travelled to London. He was detained by Metropolitan Police Officers after his 'suspicious' behaviour had triggered an 'Armed Response Unit' being called out. A Hospital Order was put in place. There were varying explanations offered for Edward's behaviour. Edward's father informed staff that a close friend of Edward's had been killed in a car crash recently and was upset, Edward himself felt that his behaviour was due to his drinks having been 'spiked.' Edward was given a 'Depot' injection but again stated he would refuse it once he was back in the community. Edward was then discharged to his father's address. A support package was put in place. However, Edward could not adjust and was soon after readmitted to a semi-independent unit close to the Hospital where he remained until mid-September 2018 and was discharged as he wished to return to his father's flat and felt the facility too restricting. Edward was still identified as having symptoms akin to earlier episodes of psychotic episodes, hearing 'noises,' believing people were 'after him,' but that despite these stated he felt well. The Consultant identified the risk as "low right now, psychosis still present but in the background now." It was planned for him to start Cognitive Behavioural Therapy (CBT) on discharge. He did not attend any of the planned sessions. There were various attempts by Southern Health EIP CCO and Psychology staff to contact Edward after discharge, some by text, CBT appointment letters, and clinic appointments made for him. Edward's response to these was spasmodic, he only responded to Home Visits but was often evasive in terms of those. He was seen in a Home Visit in early May 2019 in which he refused offers of support saying he did not need them, that he was happy living as he was, he had stopped his medication and did not need CBT.

4.19 Edward had started a relationship with his girlfriend at a point in 2019 she was seen by the family to be supportive of him and a calming influence, she did not wish to participate in this review. From then on until late December 2019 there was again a similar pattern of dislocated attendance, help offered and not taken up. EIP planned to discharge him in September 2019, but Edward responded that he wanted to remain a patient as he needed help with employment and accommodation, but it does not appear he engaged with appointments made for him in relation to that. A

letter was sent to Edward in late September 2019 from EIP saying that due to no contact his discharge was being planned. This elicited a response from Edward and an appointment with the employment specialist was made and kept by him.

4.20 In early January 2020 Edward's father contacted EIP expressing concern that Edward was relapsing into previous patterns of behaviour and paranoia. This was unusual as he had rarely contacted them previously with concerns about his son. He stated that Edward was accusing him of sleeping with his girlfriend. Edward's father was described by the call handler as being tearful on the phone and that he stated that his son was being verbally aggressive to him. Both his ex-partner and his other son describe this as being extreme behaviour by Peter both in that he was tearful and in his seeking help, something he rarely did. The call handler advised Peter to contact the Police were his son to become physically aggressive to him. The call handler than contacted Edward's mother who made it clear she could not talk as Edward was present. The call handler described her voice as 'shaky.' The call handler then contacted Edward who was later described as being 'immediately suspicious' about the purpose of the call. It was clear from the content of the conversation recorded in the Southern NHS chronology that both parents were in fear of Edward due to his escalating paranoia and threats to his father. Edward's mother disclosed to the EIP Support Time Recovery worker in early January 2020 during a Home Visit that Edward had made threats to kill his father, believing him to be having sex with his girlfriend, and that he had some months ago accused his girlfriend of having sex with another man. There is no record of these threats being recorded, a DASH completed or of them being passed on to the Police although they represented a specific threat to both Edward's father and possibly Edward's girlfriend. The plan made following this visit was to transfer care to the Acute Mental Health Team (AMHT) and arrange a 'joint family visit,' neither potential victim was warned.

4.21 The next day Edward's father contacted Hampshire Constabulary to report Edward missing and disclosed that he had been verbally aggressive to him and threatened to take his money and beat him up. It emerged that on the next day Edward had been to London, the reasons for the visit were not clear. The combined Health chronology prepared for the Serious Incident review states that Edward had been detained (he was in Southampton but had told his family he was in London) the reason for his detention was not stated and that he would be in custody and a mental health assessment conducted. This Missing Person Risk Assessment, according to the Hampshire Constabulary IMR was later changed as the level of perceived risk to Edward and others was reduced to low due to his presentation, regular communication with his family and level of cooperation with them. Plans were made with him for him to return home, which he cooperated with. Edward was seen at clinic on the next day in January 2020. Recent events were discussed. It was noted that Edward was keen to minimise the seriousness of them. Medication was

discussed. Risk was identified by the Mental Health practitioners as ‘moderate’ and that ‘some paranoia’ was noted in his presentation. His admission to hospital was not discussed.

4.22 Eleven days later in late January 2020 Police were called after Edward made threats to kill his brother and had then left the house. He was found later by Police in the town centre, registering as Homeless. A visit to the family home was arranged for the following day but was unable to be conducted due to operational demands. A telephone call was made to Edward’s Mother to apologise for the absence of a visit, and Peter’s older son was spoken to, he refuted the Threats to Kill describing the incident as a verbal only domestic. Edward was seen by an Officer; he also indicated it was a family argument that was blown out of proportion.”

4.23 In early February 2020 Police were called to Peter’s flat where his body was found. He was pronounced dead by Emergency Services at the scene. The suspect was identified to be Peter’s son, Edward.

5. Overview

5.1 Of the agencies involved in this case, Hampshire Constabulary, Southern Health NHS Foundation Trust and Solent NHS Trust had the most contact with both the victim, the perpetrator, and the family.

5.2 Hampshire Constabulary had some involvement with the perpetrator, whose behaviour, which began in 2011 as low-level crime and disorder, became steadily more serious and more concerning as he matured, particularly after his first possibly psychotic episode on holiday in July 2016. Soon after Edward's return from that holiday his family became concerned about his mental health, he attended an outpatient appointment in August 2016. Edward then threatened to harm himself by jumping from the roofs of his Father's and Mother's flats two days later in August 2016 and again a month later in September 2016. Both incidents were similar in motivation and pattern, and both ended in Edward jumping, indicating that he had a potential to cause serious harm to himself. Southern Health NHS Foundation Trust records indicate that after the second incident in September 2016 Edward was identified by them as at 'High Risk' to himself, there is no evidence of a risk formulation concerning his first hospitalisation. Records on discharge after the first of these incidents in September 2016 state no evidence of 'active' mental illness. An on-call Psychiatrist from Southern Health NHS Foundation Trust attending that incident informed the Police attending that; "she was told Edward ran off the roof, swallow dived and flipped in the air landing on his back. This is confirmation of significant intent to end his life." This information does not appear in the Southern Health NHS Foundation Trust nor Solent NHS Trust documents provided for this review. As previously stated, a safeguarding notification from the Police on the first incident in August 2016 was mistakenly not sent to other agencies by the Police Officer in attendance.

5.3 Regarding the second incident on the roof of Edward's mother's flat in mid-September 2016 the Police IMR records that when the AMHT arrived at the scene to help*,* Police records state that they said, they 'could not give much background'. This despite records indicating that Southern Health NHS Foundation Trust and Solent NHS Trust had, had substantial outpatient and inpatient contact with Edward over the previous month. It is not stated whether the barrier was an IT matter or an interpretation of patient privacy requirements.

5.4 It was noted on both events that Edward had a knife in his possession, and on the second event he indicated an intention to harm himself with it. The chronology from Hampshire Constabulary acknowledges gaps in information sharing in both incidents. In the first incident, a Police warning marker was never raised on their system alerting staff and officers to increased risk due to mental health, substance misuse and possession of weapons. A CA12 notification was completed by Police as per guidelines and shared with Adult Social Care. The Police referred to the Adult

MASH and added a DA warning marker identifying Edward's mother at medium risk from Edward, this assessment was verified by the police MASH Co-ordinator team.

5.5 It should be noted that Police attendance and response was always sensitive to the needs of the adult at risk and used the least intrusive methods in managing the case at the time and afterwards in considering whether and what action should be taken. Its approach was clearly driven by the welfare needs of Edward. This approach has been recently reinforced by the Hampshire Constabulary Adult at Risk Strategy and Plan 2021-2024. This is based on the National Vulnerability Action Plan and learning from reviews. This has been subject to recent refresh and covers the following strategic objectives (alongside a tactical delivery plan).

1. Through effective partnership working, seek to improve how we identify, assess, and respond to those at most risk of harm.
2. Maximise opportunities to deter, prevent and stop those causing the greatest harm to others.
3. Enable our staff to provide the best possible service to vulnerable adults.
4. Promote a problem-solving approach where everyone has a role to play; identify and adopt national best practice through objective, evidence-based evaluation and peer reviews.
5. Create opportunities to gain feedback and insight from those we support, in order to consistently improve what we do and maximise positive end outcomes. In accordance with the Making Safeguarding Personal Principles.

5.6 Southern Health NHS Foundation Trust medical notes between February and March 2017 record the concerns expressed by Edward's mother describing her son as having 'previously intimidated' her and being fearful of him should he discover she had requested a Mental Health assessment and describing him sleeping with a knife. The Southern Health NHS Foundation Trust Team chronology states his mother felt Edward to be 'psychotic, losing touch with reality and refusing to see anyone from the EIP Team.' Southern Health NHS Foundation Trust records in this period state Edward to be non-compliant with medication, using alcohol and cannabis and avoiding contact with them. Despite this Southern Health NHS Foundation Trust notes state that in early March 2017, they were considering discharge as Edward was not interested in further EIP input was 'cutting down on cannabis, had capacity and mood good'. It does not appear that Southern Health NHS Foundation Trust sought information from any other sources before deciding on discharge. Records show that Edward's GP was informed of the discharge from EIP in late May 2017. The plans to discharge Edward appear to be based on his non-compliance and his own testimony as to his well-being and did not consider the level of need or risk to self and others as expressed by his Mother. Records do not indicate what if any plans were made to handover responsibility to others or enable those with oversight and responsibility of Edward (his parents in particular) to communicate future concerns about his risk to self and others. In short there was no discussion with the

family to help them develop a contingency plan in the event of relapse. Edward had family members who were interested in his care and had repeatedly demonstrated this. He believes this failure to have a family meeting when he was well enough to agree a strategy with his family for when he was not well was significant.

5.7 This failure to investigate further and to seek information from other sources to verify or discount a view held on Edward was also apparent in the GP notes in late May 2017 in which Edward failed to attend an appointment. There was no follow up by the Surgery when Edward failed to attend a 'book on the day' appointment at the surgery on that day, even though Edward had attended the Surgery two days before and had expressed concerns about his mental health. Two days after this missed appointment he was admitted to hospital after suffering from an episode that led to him harming himself.

5.8 There were, some months after the events in August and September 2016 further indications that Edward may present a direct risk of harm to his family. At the end of April 2017 Police attended Edward's mother's flat following a disturbance at the property. His Mother wanted Edward to leave the property and had in desperation according to her changed the locks to ensure he could not return. When Police attended, his Mothers recollection is that Police did not speak with her separately. She states she was not seen on her own and crucially a follow up visit to do so which was tasked to the Safeguarding Team does not appear to have taken place. This meant that the victim did not have the opportunity to safely express the significant level of threat she felt under to the Police. Police records taken at the time indicate a conversation between the attending officer and the victim. This includes her remarks to the Police attending the incident that he 'made no direct threats' to her. This may have been a deliberate strategy to minimise any police action against her son, and an example of the minimisation which often occurs within Inter-Family Domestic Abuse or may have been because she was not seen on her own and did not want to anger him. The Hampshire Constabulary IMR states that a DASH was completed which was assessed as 'Medium' the Officer reviewing the case for this DHR felt that given the deteriorating mental health of the perpetrator and the breakdown in his familial relationships, this should properly have been assessed as 'High' meaning this would then have been referred to the High-Risk Domestic Abuse (HRDA) process. It is also a concern in relation to this that Edward's Mother has stated that at no time has she ever been interviewed on her own by Hampshire Constabulary. Although her recollection is at odds with Police recording, it is of note that neither her nor her older son were aware this was a Domestic Abuse case.

5.9 A month later, at the end of May 2017, Hampshire Constabulary were called to a disturbance at Peter's flat, to which Edward had moved. It was reported that Edward was armed with a knife and a piece of broken glass and was threatening his father and brother. When Officers arrived, Edward attempted to throw himself out of

the window. Peter was offered added security for his protection by attending officers which he declined. Peter was assessed as Medium Risk using the DASH assessment tool at the scene. This again failed to recognise the presence of drug use, mental health and use of weapons and the escalating frequency and duration of incidents, factors that should have increased the risk level to High, which again would have led to HRDA oversight. Hampshire Constabulary records state that “The level of harm he (Edward) was prepared to do to himself was known to be at the higher risk end of self-harm.” It was also noted that the parents may minimise the risk they themselves were at stating, “Whilst he (Edward) largely made threats to harm himself…his parents may have tended to minimise the impact on them and in the original call log it states he was threatening his Father and Brother with broken glass.” The Police Officer attending did complete a CA12 notification submitted to ASC of their attendance. The reviewing officer felt that the detail it contained could have been improved. Due to the DASH risk assessment on both occasions being assessed as Medium this incident was not shared with other agencies in the city through the HRDA process. A DVPN [7] was not considered by the attending officer, Edward was not arrested but detained for his own safety, so therefore with consideration of the circumstances and him being in psychiatric care a DVPN would not have been appropriate. Adult Social Care (ASC) have since indicated they were aware of the incident. Their IMR states that, “there are no records of any threat towards them by *Edward*, or that they perceived they were threatened by him.” The ASC IMR notes that Edward was then detained under section 3 of the Mental Health Act (MHA). This suggests that ASC may not have been aware of the significance of the aggravating factors in the case, the previous behaviour, and the possession of and threat of using weapons. We do not know of course if this would have affected the response of ASC had they been given this information.

5.10 The Police IMR author believes the Medium grading, which they felt to be wrong, may have been due to a) that the DASH form was designed primarily for ‘intimate partner violence’ and has to be adapted by officers in cases that involve family members. And secondly that while the “medium risk assessment was based on the numerical values of the MASH operating procedure and the views of the attending officer and is generally in line with the risk assessment guide within the

[7] https://www.app.college.police.uk/app-content/major-investigation-and-public-protection/domestic-abuse/arrest-and-other-positive-approaches/domestic-violence-protection-notices-and-domestic-violence-protection-orders/#:~:text=In%20order%20for%20a%20DVPN%20to%20be%20available%3A,violence%20or%20threat%20of%20violence%20by%20the%20suspect.

form…... the Police IMR author is of the belief that there were some indicators that were not fully explored.

5.11 The Panel would agree with the Police IMR author's supposition and add to reinforce that Edward had twice demonstrated an intention to seriously attempt to harm or kill himself. It is recognised that this can often mean an increase in risk of those around the person with suicidal intentions. This, along with Edward's deteriorating mental health, and the use of weapons does not appear to have been recognised by the Officers attending in this case. The Hampshire Constabulary IMR author believes taking these factors into account that the DASH assessment should have been recorded as 'High' which would as in the previous incident had led to the case being taken to HRDA and offered an opportunity for the creation of a multi-agency risk management plan.

5.12 Southern Health NHS Foundation Trust assessed Edward's risk as 'Low' on admission and this assessment remained so after the assault on a member of staff at Parklands Hospital. Edward had punched the member of staff to the left side of his face injuring his eye and cheek causing swelling, the victim of this assault required medical treatment. The information on the severity of the assault on the staff member that it was identified as Actual Bodily Harm or the completed DASH was not known to Solent NHS Trust, with their IMR author stating, "there is nothing in Peter's or Edward's records to indicate that any Domestic Abuse or harm of any kind was occurring within the family." The Solent NHS Trust IMR noted that as details of the assault were not known, the assault was seen as Edward pushing the member of staff and described as a 'common occurrence', they therefore were not aware of the degree of the assault and did not see it as a wider indicator of risk.

5.13 The Hampshire Constabulary IMR states that the member of staff that was assaulted by Edward at Parklands Hospital later contacted the Police to say that they did wish to proceed with prosecution. The issue of prosecution appeared to rest on Edward's 'capacity.' The Police IMR author has highlighted the belief held in this case by Hampshire Constabulary Resolution Centre[i] that if a perpetrator is deemed to lack 'capacity' charges should not be laid as prosecution is unlikely to be successful. The Police IMR author states that view to be 'erroneous' and cites the following "The fact that a person is in hospital at the time of the offence, has a diagnosis of a mental disorder or had been detained under s136 is not in itself a reason to drop any investigation". Edward in this case was felt to have 'fluctuating capacity' and it was decided to write to the victim outlining the options and consequences to the perpetrator if prosecution were to proceed. The Police IMR author rightly identifies this as being "not appropriate" and that the letter regarding plans for Edward's care should have gone to a supervisor and not the victim. The Panel would add to that, believing that such practice has the danger of retraumatising the victim and reinforcing an often-held view by victims that somehow, they hold responsibility for the perpetrator's behaviour. Fortunately, this victim had no ongoing relationship or connection with the perpetrator and hopefully the damage of this communication was limited. The IMR author ensured that all similar cases were audited, and the panel assured it was not a systemic issue.

5.14 Edward was reported missing by his family in May 2018 and was found attempting to scale Big Ben in London. He was detained under Sec 2 of the MHA in

central London by the Metropolitan Police. Edward's missing status at the time was recorded by Hampshire Constabulary as 'No Apparent Risk' despite the previous attempts at suicide, history of psychotic episodes, possession of weapons and drug misuse. In addition, and the fact that his pattern of climbing buildings and jumping off them was being replicated in London did not seem to be noted by the Metropolitan Police as a factor indicating higher risk. This assessment may have been applied once the call taker received information from the Metropolitan Police that he was in their custody within 3 hours of being reported missing" to Hampshire Constabulary by his brother. The Metropolitan Police held primacy and informed Hampshire Constabulary when he was detained. Hampshire Constabulary took appropriate action by undertaking checks with local hospitals, they identified possible location to start search, they asked investigative questions in addition to mandatory questions and contacted the Metropolitan Police as soon as possible once advised Edward was in their care. The Metropolitan Police also asked relevant questions of Hampshire Constabulary regarding Edward's mental health. A risk assessment when his brother made the report was not completed.

5.15 There is useful learning to draw from this case for the future, in January 2020 there were two missing reports made on Edward. The first made in early January 2020, Edward's father called in to the Police prior to his Manslaughter to report Edward as a missing person. The call handler recorded this missing episode as medium risk, but this is then reduced to 'Low risk,' this decision followed an appropriate rationale and supervisory oversight. They correctly identified the mental health history of Edward as a risk factor however saw this as mitigated by the fact that this presented as a planned decision made by an adult, combined with information from the family that he was having regular FaceTime contact with them. A number of actions were taken by Response and Patrol officers to locate Edward and there was regular supervisory oversight up to the level of Inspector. However, Peter had disclosed to the call handler that Edward was becoming violent with him, was not in control of himself and had threatened to and stolen money from him. There appears to be a lack of recognition of the economic abuse element or the wider issue of domestic abuse. Peter did state and believed according to his family that Edward is a risk only to himself. This information is indicative of Domestic Abuse and specifically Coercive and Controlling Behaviour and should have alerted the call handler to this possibility. The incident was categorised as a Missing Person' with the Officers responding appropriately to that categorisation as Edward an adult, was in touch with his family. The IMR author for the Police spoke with the Police Officers tasked with the incident and found that neither Officer considered the issue of Domestic Abuse being a possibility. The threats of violence made by Edward to Peter reported to the call handler were not picked up in this process. Call Handlers have since received further training on the minimisation by victims reporting domestic abuse.

5.16 In regard to the first report in January 2020 it is clear from the Police Records and the comments by the Police IMR author that when Edward was found to have returned home the information relating to disclosure from Edward's father about his son threatening violence were not addressed. Police did not attend the home address as planned at the request of Peter, rightly in the view of the Police IMR author, due to fear of aggravating a volatile situation with someone in a mental health crisis and following a risk assessment no other Police contact was felt needed

to be made. It was felt that as Mental Health Services were to attend this was the most appropriate agency with the right expertise to respond to someone in crisis. However, the focus of the Mental Health Team in most cases of contact with Edward was on his health and well-being and not the risk he posed to his family. A follow up visit afterwards would have been the most appropriate to complete a DASH risk assessment once the mental Health crisis was averted. This may have been a missed opportunity to have identified from the family any elevated sense of risk and fear they may have had of Edward. A PPN1 was submitted and shared with Adult Services Connect concerning the incident.

5.17 The second report was made two weeks later by Edward's mother stating he was not taking his medication and had made a threat to kill his brother. Edwards mother later contacts the Police stating that police were no longer required, and all parties were separated, she did not wish police to attend that evening. She was informed as the incident required further Police visit but due to operational reasons this did not happen though all parties were spoken to and described it as a family argument that had got out of hand. A Police supervisor had assessed the risk in the control room and determined that the Threats To Kill (TTK) were likely to not be genuine based on the fact that despite prior Domestic Abuse warning markers there had been no recent 'stand out' incidents whereby Edward has harmed another. Despite previous callouts and two DASH Risk Indicator Checklists being completed. The Public Protection Notice (PPN1) was not completed.

6. Analysis

6.1 The Manslaughter of Peter by his son Edward can only be understood by examining the events that led up to that tragic event and the responses of the agencies involved in those. We will examine the degree to which the family were helped to understand and be protected from the threat posed by Edward and the degree to which agencies in Southampton worked together in this endeavour.

6.2 One of the most striking features of this case is the apparent lack of multi-agency working and poor information sharing between agencies in Southampton that were working with Edward and his family. An example of this is the IMR author from Solent NHS Trust who reported that “There are no indicators or disclosures of harm or Domestic Abuse during any episodes of care provided to Edward or Peter.” As the IMR author for Solent NHS Trust describes Edward “had 3 episodes of care with Solent Services, 2 with our in-patient mental health team in late September 2016 and in late May to mid-June in 2017. During these times he received care from Solent’s Psychiatric Intensive Care Unit, (PICU), and Solent’s Acute Mental Health Unit, (AMHU). He received treatment for delusional thoughts and self-harm. Peter also received treatment from Southern Health NHS Foundation Trust’s Mental Health Services.” These periods of in-patient care were following three incidents in which Edward had twice thrown himself deliberately from the roofs of his parent’s property, the second in which he used a knife threatening to harm himself and later threatened his brother and father with a knife and broken glass before jumping out of fifth floor window and attempted to slash his neck and wrists while hanging out of the window. He also within the time frame covered by the IMR assaulted a member of staff at Parklands Hospital, who required medical treatment afterwards.

6.3 It seems that throughout these and following events the Health Services involved had no sense that Edward could pose a direct risk to his family, despite the first event being described by an on-call Psychiatrist at the scene as a “significant attempt to end his life.” No link was made which acknowledged that Edward’s Psychotic episodes and his extreme behaviour could put others at risk. Edward’s family, in particular his mother contacted services several times from the first incident in 2016 to the manslaughter of his father in February 2020 to inform them of her fears of living with Edward. Edward’s mother told the Mental Health Team worker during a home visit in February 2017 that she was ‘intimidated’ by Edward and expressed her fear of him should he find out she had spoken to them. She also told them that he carried a knife and took it to bed with him. It was known that the relationship between Edward and his parents were difficult with Edward moving from one parent to another following arguments. In one event Police were called after Edward’s mother had changed the door locks to prevent him getting into the house. In addition, Edward had a strained relationship with his father and brother; there was an incident to which Police were called in which he was threatening his brother and father with a knife and broken glass in which a DASH was completed. The IMR from

Southern Health NHS Foundation Trust records that it was made aware at the end of the first week of January 2020 that Edward had made threats to kill his father as he believed him to be having an affair with his girlfriend. This information was not shared with the Police or Solent NHS Trust. The Southern Health NHS Foundation Trust Domestic Abuse Policy states that in cases of likely 'significant harm' disclosures can be made to the appropriate services. This information was credible and indicated that possibly two people were at risk of serious harm at a time when it was known by the service that Edward's mental health was deteriorating, there is no record of disclosure of this information being even considered as a possible action to manage Edward's potential risk.

6.4 No other family member except for Peter was offered Domestic Abuse advice or referred to a specialist Domestic Abuse service from first referral to Mental Health Services in July 2016 to the Manslaughter of Peter by his son in February 2020. This, despite information from Edward's mother who expressed numerous times to both Acute and Community Mental Health Services her fear of Edward and his threats to 'smash the house up,' his volatile temper, and use of cannabis and alcohol increasing and her concern about this. Despite this knowledge the only help provided was to offer 'Carer's Support,' Family Therapy and advice to call 999 "if she felt unsafe". Southern Health NHS Foundation Trust were aware of Edward's capacity for violence and the assault of a staff member at Parklands Hospital Hampshire in May 2017 was evidence of this. Solent NHS Trust were aware of the assault but not of the severity of it. Southern Health NHS Foundation Trust and Solent NHS Trust appear unaware of how fearful his family members were. Despite Edward's mother and brother having expressed concern about Edward's deterioration, behaviour, non-compliance with his medication, mood swings and increasing use of drugs and alcohol this was not shared with Solent NHS Trust. Southern Health NHS Foundation Trust responded to these concerns and would often Home Visit or call, crucially it did not flag to them an indication of the danger the family were in, nor that this was a case of Intra-Familial Domestic Abuse (IFA) or Adult Family Violence (AFV). This failure to recognise AFV is not unique to services in Southampton, 'Standing Together' analysed a number of DHR's involving families experiencing Adult Family Violence in their 'Standing Together DHR Case Analysis' 2019 document and noted that there were within the cases examined; *"serious failures in identifying Domestic Abuse , assessing risk, and referring victims to appropriate support services by a range of agencies, and a noticeable lack of understanding of dynamics of violence and abuse within a familial context"*.[8]

[8] Executive Summary London Domestic Homicide Review (DHR) Case Analysis and Review of Local Authorities DHR Process Bear Montique October 2019 pages16&17

6.5 This inability to see the family members as potential victims was exacerbated by the nature of risk assessment undertaken by the Health Services in this locality, who of all agencies had prime responsibility for Edward's care and the most contact with Edward and his family. It is evident both from the IMR's submitted and from the Southern Health NHS Foundation Trust Chronology of contact that Risk Assessments were prompted by key events concerning care-admission and discharge and rarely seem to have been influenced at all by information provided by Edward's family or events such as further assaults or information provided of risky behaviour such as drug and alcohol use or non-compliance with medication from family members.

6.6 There is no reference to information sought from or provided by other agencies involved, for instance, the Police nor family members who had the most sight of Edward in times of crisis. In short there was no evidence of partnership in their work with Edward. This lack of a multi-agency approach meant that risk assessments were undertaken by clinicians using one source of information only, the perpetrator. Information provided by Edward was not verified nor were assumptions by clinicians in terms of Edward's progress checked out with other sources. Although Home Visits were undertaken there is no evidence of information being sought from family members away from Edward to test out hypotheses in terms of Edward's response to treatment. The Panel is also concerned that the severity of the assault by Edward on a member of staff in Parklands Hospital resulting in injuries that would have warranted a charge of causing 'Actual Bodily Harm' had it been proceeded with and injuries that required medical attention and therefore indicating a potential risk to members of the public as well as family members, was not known about by Solent NHS.

6.7 There is evidence of failure to use such information to build a picture of the risks posed by Edward. This meant that Southern Health NHS Foundation Trust's views of Edward's risk were limited. This is particularly evident as Edward's behaviour and symptoms of paranoia developed, and risk factors such as drug misuse, use of weapons and evidence of controlling behaviour and threat grew through the years leading up to the Manslaughter. It seems that clinicians assessing Edward did not consider the possibility of 'Disguised Compliance' [9]when interviewing Edward. This and the absence of seeking family views in assessing Edward made it possible for Edward to convince professionals of progress and a level of recovery

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[9] Disguised compliance involves adult, parents and carers appearing to co-operate with professionals in order to allay concerns and stop professional engagement (Reder et al, 1993 https://learning.nspcc.org.uk/research-resources/learning-from-case-reviews/disguised-compliance#:~:text=Disguised%20compliance%20involves%20parents%20and%20carers%20appearing%20to,they%20face%20may%20be%20unknown%20to%20local%20authorities.

that was not shared by Edward's mother and brother particularly. The family were aware to a degree that Mental Health professionals were not, that Edward did not want or value their intervention into his life, and that he therefore was motivated not to be open and honest with them, but in fact to manipulate their view of him to enable him to be free of their oversight. His mother and brother feel that Peter encouraged that sense that Edward was not a danger until the last few weeks of his life.

6.8 The Panel believe that Risk management by the Mental Health Services was not evidence based. In response to the most serious incidents, Edward was hospitalised under the Mental Health Act 1983. He was then after a degree of recovery discharged into the care of his family. There is no record of liaison with the family in terms of managing Edward's return and their own safety. There appears then to be a pattern in which Edward's compliance with the Services commissioned to support him in the community fell away, failure to keep appointments, rehabilitative activities offered not taken up, concerns expressed by the family in terms of his presentation and behaviours such as anger, aggression, taking a knife to bed with him, the use of alcohol and drugs and crucially non-compliance with his medication were not seen as risk factors in terms of the family, nor by the family. These crucial indicators of increasing risk within a Domestic Abuse framework were only treated as clinical matters to be addressed. The response to this would then be increased Home Visits, further hospital appointments made etc. One example of such practice was the response by the Southern Health NHS Foundation Trust Mental Health Team in early January 2020 following concerns expressed by the family, to suggest a 'joint family visit', in response to Edward making threats to kill his father, the purpose of which was not stated. The visit did not go ahead as events overtook the plan, but had it done so in a time of escalating risk such a meeting could have put family members at further risk. At no point were family members offered help and advice as potential victims of Domestic Abuse through all the contacts with Southern Health NHS Foundation Trust and Solent NHS Trust. The only advice offered to Edward's parents was to call the emergency services if in fear physically of Edward or to offer support such as 'Family Therapy.' None of these being evidence- led responses to Domestic Abuse. This failure to identify Inter-Family Abuse or Coercive and Controlling behaviour and provide advice and guidance meant that Edward's father, against whom Edward had developed a particular grievance- believing he was sleeping with his girlfriend was not enabled to move to a position of seeing his son as a potential danger to him, nor being equipped to read the danger signs when Edward's grievance thinking escalated. Crucially, Hampshire Constabulary were not informed by those workers to whom this information was disclosed to, which meant they were not prompted to re-assess the seriousness and imminence of risk facing the family. The Mental Health professionals visiting did not complete a DASH with the family, despite their open recognition of their fear of Edward.

6.9 As stated above none of the services involved, apart from Hampshire Constabulary to a degree, treated family members as victims or potential future

victims of Domestic Abuse. This failure meant that the family remained in danger, were not provided with advice or strategies to help them either identify escalating danger to them, nor to have ready made plans to make themselves safe. The response by Hampshire Constabulary in May 2017 to a disturbance at Peter's flat illustrates this. Edward had threatened his father and brother with a knife and broken glass, he had tried to harm or kill himself using those weapons and throwing himself out of the window, before being subdued by the Police. Edward's father declined added security on the grounds that his son would be detained in Hospital, and he would not need it. There is no evidence of this being discussed with him, nor of the risks he faced when Edward was discharged. The Police did not know how long Edward would be detained and were not informed of his return to the community. This placed the responsibility on Peter to keep himself safe. The Hampshire Constabulary IMR states that Officers attending from Hampshire Constabulary did complete a DASH and Peter was assessed as being at 'Medium Risk' however Peter did not consent to his information being shared. A safeguarding notification was shared with ASC relating to Edward. This review has outlined above that Adult Services took no action in response to these notifications. In addition, Adult Services state in their IMR that they received three notifications for Hampshire Constabulary, who themselves record all six being sent.

6.10 Crucially in none of the incidents were family members provided with advice or contact details of appropriate domestic abuse services, Peter was spoken with in private but neither Edward's mother nor brother remember being spoken to away from Edward. Only when this DHR was commissioned, and the chair discussed this with the family that they began to appreciate that they had been victims of Domestic Abuse. This is of particular importance in the case of Edward's father, who believed that he and Edward could largely manage on their own and did not, unlike Edward's mother feel threatened by Edward until the immediate period leading up to his Manslaughter in February 2020. The DASH did not lead to a recognition by the family that they were the victims of Domestic Abuse. The Panel felt that the DASH was not a reliable assessment tool in relation to Intimate Family Violence or Abuse. Whilst Peter was offered added security on one occasion this failure by some agencies to see Edwards mother, brother, and girlfriend also as victims prevented a risk led added security measures and disruption approach being taken.

6.11 What is clear from these events is that the DASH used in cases of Intra Family Domestic Abuse or IFV (Intra- Family Violence) did not lend itself to accurate assessment of risk. The IMR author from Hampshire Constabulary felt that the DASH risk assessments that were completed were assessed incorrectly as 'Medium' rather than 'High.' This was a crucial error as a 'High' score would have involved the HRDA process and opened the case to involvement of Specialist Domestic Abuse Agencies and provided Health agencies with an opportunity to share information with other agencies. Individuals assessed at medium risk with consent can also be referred but

Peter refused consent. The research by Standing Together DHR Review 2019[10] identifies how families normalise and minimise the risk posed by their loved ones. The Panel felt the DASH itself contributed to this error as the underpinning evidence base and the prompt for scoring is primarily based and focussed on 'Intimate Partner Abuse.' The Panel is aware that Edward was involved with a girlfriend for a year before the incident and she is not referred to in any of the IMR's. His girlfriend also should have been considered at risk from Edward at this time as he believed she was having a relationship with his father and others, jealousy being a noted risk factor in domestic abuse. The family were not offered advice and information in terms of Domestic Abuse. Although DASH was used appropriately by the Police its apparent limitation in terms of identifying Intra Family Domestic Abuse (IFA) or violence (IFV) suggest that the use of it may have failed to alert Officers to the actual level of risk. This prevented a Multi- Agency approach being triggered. At the time the risk indicators which were visible were access and use of weapons, deterioration in his mental health, suicidal ideation, drug, and alcohol use, controlling and coercive behaviour as well as his relevant previous behaviour.

6.12 In addition, the Police response to the assault by Edward on a member of staff from Parklands Hospital is concerning. Due to the perceived lack of capacity that they felt Edward had at the time of assault they believed they should not seek to prosecute. The response to this situation, writing to the victim outlining this and likely consequences for the perpetrator should the victim wish to proceed was not good practice in the Panel's view, putting as it did the onus on the victim, who had already indicated a wish to prosecute to make a relatively sophisticated judgement as to the merits of such an action. This seems to the Panel to place the victim with an unreasonable dilemma. The Panel has been assured by Hampshire Constabulary that following additional exploration this does not appear to be a routine issue and significant development has occurred in force to negate such misinformation.

6.13 Assaults on NHS staff are treated with a zero-tolerance policy by some NHS Trusts. In February 2020, the NHS joined forces with the police and the Crown Prosecution Service to approve a joint agreement on offences against emergency workers. This will ensure that those who act violently and with criminal intent towards NHS staff are swiftly brought to justice.[11]The panel are aware that Operation Cavell is now in place in the Hampshire Force with assaults on NHS and care staff being screened by a team of four Inspectors.

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[10] Standing Together: DHR Case Analysis 2019 Executive Summary London Domestic Homicide Review (DHR) Case Analysis and Review of Local Authorities DHR Process Bear Montique October 2019

[11] https://www.gov.uk/government/publications/violence-against-nhs-staff-letter-to-the-workforce/violence-against-nhs-staff-letter-to-the-workforce February 2020

6.14 What is striking to the Panel is the absence of the involvement of Adult Social Care and safeguarding services through all these events involving Edward and his family. Again, this is a factor which the Standing Together research identifies as common in cases such as these. It states," The curious near-systematic invisibility of Adult Social Care (through lack of referrals or NFA taken by ASC), and internal Adult Safeguarding processes was striking, even though most of the individuals concerned were either elderly carers or people with significant support needs in terms of their mental health."[12]. This finding appears to be mirrored in this case. ASC state in their IMR that they were notified by the Police on three occasions- twice in September 2016 and once in January 2017 of their involvement with this family. The Police IMR differs in that it states there were two further incidents in which notifications were sent to the ASC Team and two additional in which mistakenly notifications were not sent. The ASC IMR does not specify the contents of the CA-12, it received but the date the notification was received the middle of September 2016 would mean it reasonable to assume that details of the two serious suicide attempts Edward had made in September from the roofs of his parent's homes would have been included. The third CA-12 received by ASC in late April 2017 records that; "It was stated that Edward made some verbal threats of wanting to damage or burn down her (his mother's) home. He did not make any threats of harm towards his mother. No offences were disclosed." This suggests a high threshold in terms of the perception of threat level as being serious enough to warrant intervention. The ASC IMR states that "There is no information … that clearly indicates any formal Care Act Safeguarding duties existed. There was no information that clearly indicated that either parent was vulnerable/at risk. What information that was communicated was concerning risks about Edward's mother. These would not have met the Care Act Safeguarding criteria."

6.15 The Panel is aware that again such gaps in practice are not unique to this area. The 'Standing Together Case DHR Analysis' (2019) Report identifies a pattern of agencies falling to identify and respond to intra-familial Abuse or violence and marginalising elderly parents who are at risk. The document identified many of the issues that we believe existed in this case, in particular mental health assessments that did not include risks to family members, lack of involvement of the family and lack of liaison with other agencies in planning care for the individual. Assessment and treatment Plans without a full picture of risk and issues concerning the safety of carers involved and that any liaison with the family was usually initiated by the family rather than the services involved.[13]

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[12] Standing Together: DHR Case Analysis 2019 Executive Summary London Domestic Homicide Review (DHR) Case Analysis and Review of Local Authorities DHR Process Bear Montique October 2019

[13] Ibid

6.16 In summary, the Panel believe the poor information sharing between the agencies, the lack of identification of a pattern of deteriorating behaviour in Edward and a corresponding increase in the level of risk posed to his family members, coupled with a lack of liaison with the family, despite Home Visits being undertaken meant that Edward's risks to his family were not identified and managed. This was made worse by the failure to identify Edward's behaviour as violent, coercive, and controlling Domestic Abuse. The issues that Mental Health clinicians were working with Edward on- drug and alcohol misuse, non-compliance with treatment, his paranoia were not identified as potential risk issues in terms of Domestic Abuse also.

6.17 Edward's family were not alerted to the risks they were living with or informed that they were the victims of Domestic Abuse including economic abuse by the professionals involved. Edward's mother, when asked by the Panel Chair directly, told the Chair that neither she nor Edward's brother recalled at any point contributing to a DASH risk assessment that had been completed following her call to the Police. Edward's Mother was familiar with the DASH due to having been in a previous abusive relationship. Edward's father like many other victims of IFV and IFA felt that he was able to manage the perpetrator and minimised the threat posed by his son, for instance he declined added security as his son was at that point hospitalised. There is no evidence that attending officers discussed or tried in any way to challenge his belief in this. This is a common feature identified within the Standing Together review.[14] In cases such as this it recommends that a MARAC referral (or in this area a HRDA) is made based on professional judgement, irrespective of the victims wishes.

[14]Standing Together: DHR Case Analysis 2019 page 14 "Agencies should always refer to the MARAC based on professional judgement when information is limited, and the victim/survivor is perceived to be minimising the risks/is unable or too fearful to disclose the full extent of the abuse"

7. Conclusions

7.1 The lesson from this enquiry is that Services in Southampton find it difficult to identify and respond to Intimate Family Violence (IFV) or Abuse (IFA). This is made worse by family members that live with Intimate Family Violence or Abuse themselves not being able to identify it, even when they have been previous victims of Intimate Partner Violence. There are numerous occasions when Services were told in specific terms of the family members being afraid, being threatened, including threats to kill alongside existing known risk indicators- poor mental health, suicidal ideation, threatening to and stealing money, the possession and use of weapons and drug and alcohol misuse. All services, apart from the Police treated the family exclusively as carers and not victims.

7.2 The Police response did identify the family as victims and offered added security to Edward's father's property in response to an incident of IFV. They also completed a DASH on two occasions and shared information appropriately. This did not secure the family's safety for several reasons. Firstly, the DASH only scored 'medium' risk on both occasions it was completed, and Peter did not want his information shared with specialist support agencies. Part of the explanation for this is the Panel believe, due to DASH not being designed for and therefore not accurate in identifying and predicting IFV as identified by the Standing Together research. Many of the scores are linked to a victim's perception of threat, fear, instances of abuse etc which, when a victim is not aware of being a victim of domestic abuse will score low and the evidence that victims in these cases may minimise their level of risk. The other issue may be how the DASH was approached in the two occasions it was used. Edward's mother when asked about the DASH said that she had never been spoken to on her own, nor as far as she knew had a DASH been completed on her. Hampshire Constabulary require that Officers do not take a tick box approach with victims when assessing risk, endeavouring to complete it in a conversation as opposed to completing a form. However, it appears from the family's recollection that they did not tell Edward's mother or brother that this was a domestic abuse incident, both presented as intelligent and able individuals who assure the review that this was never indicated by any agency and that if they had been told they would have informed themselves of what this meant in terms of protecting themselves and Edward. Finally, Hampshire Constabulary must be commended for their sensitive and considered approach to managing Edward. They were always focussed on his safety and well-being.

7.3 Solent and Southern NHS Services were also unable to identify the family members as victims in the Panel's view. In none of the records is there any recognition of the risk posed by Edward to his family or members of the public

even though he had assaulted a Healthcare worker. Consultations by senior medical staff show little evidence of linking the extreme behaviour they were witnessing to risks to the family. And while front line mental health staff were in contact with the family and witnessing and feeding back issues of poor compliance, drug and alcohol misuse and threats to family members this does not seem to have translated into a recognition of the risks he may pose to family. This has been identified by the Standing Together as a national problem. The Domestic Homicide Project Spotlight Briefing #1: Adult Family Homicides published in January 2022 by the Vulnerability Knowledge and Practice Programme (VKPP)[15], which was established by National Police Chiefs' Council and the College of Policing identifies these issues as a common theme and therefore should be responded to systemically. There also appears to be an issue which this case has revealed of information sharing within NHS services in Southampton. A disclosure was made to EIP of Edward having delusional thoughts about his father and his girlfriend and filming family members to evidence his fears, making threats to kill his father, and possibly presenting a danger to his girlfriend during a meeting in a café in Southampton in early January 2020. There is no evidence of this information being passed on to the Police or Solent NHS Trust. We do not know if it had been it would have prevented the tragedy but clearly is an issue to address.

7.4 Finally Adult Services had no role in this case, although they were forwarded information by the Police and so were aware of it. The system of information sharing appears to be unreliable in that two of the notices sent by the Police were not received or at least identified by Adult Services. The other issue this case has revealed is that there is a high threshold before which Adult Services would become involved, and that in this case there was no information that clearly indicated that either parent was vulnerable /at risk The Adult Services IMR author summarises stating; "what information was communicated referred to Edward's mother... these would not have met the Care Act's safeguarding criteria".

[15] /Research/AFH%20Spotlight%20Briefing_FINAL.pdf

8. Lessons to be learnt

The lessons to be learnt from this tragedy are:

1 That communication between the agencies involved in this case was sporadic, The Panel view was this would have been improved by the triggering of a MARM meeting by any of the agencies involved.
2 The Panel have learned there are wider issues related to the MARM process. There is potentially a lack of confidence in the MARM process for instance NHS record MARMs on the Electronic Patient Record but have no read code to extracting the number of MARM referrals so cannot audit the process with ease and MARMs triggered by housing providers do not routinely secure appropriate attendance.
3 Issues in the sharing of key information were identified with stating they ASC received three PPNs and Police records state five were shared.
4 Had Domestic Abuse been assessed effectively on all occasions it is highly likely a referral to HRDA would have been made.
5 That it is difficult for Services to Identify and respond to IFV and IFA
6 The victim's role as a carer was not recognised by agencies dealing with him.
7 That the focus of all agencies involved in this case was away from those with close relationships with the perpetrator and directed only on him
8 That the assessment and management of risk of harm such as the corelation with assaults on staff is not well developed within key agencies, and that a by-product of that is an unwillingness or at least a lack of recognition of the importance of information sharing (particularly within services operated by the NHS).
9 The family were not helped or provided with advice to manage the risks posed by Edward and so remained unaware of their vulnerability. A common theme from the Standing Together thematic review and again evidenced in the VKPP briefing January 2022.
10 Edward's relationship over the previous year with his girlfriend was not visible to any agency involved with Edward.
11 There was a confusing number of teams and professionals involved in the management of Edward's mental health. This made it difficult for his family to access help, advice, and support. There was no single Point of contact.
12 No agency signposted to DA services presumably because they did not identify it as such or because consent was not given.
13 The management of threats to kill varies according to agencies, with the Police using a systematic approach which analysis risk in terms of the 'Real and Immediate' nature that other agencies could learn from. Housing has a Priority Index Tool which is an aid to staff assessing risk with threats of this nature.

14 Some practice was evident that was potentially dangerous- for instance EIP staff suggesting a joint family meeting in response to the disclosure of Edward making threats to kill.
15 Managing the issue of deterioration in Edward's case by Mental Health workers did not include safety plans for family.
16 The physical and emotional impact these events have had on the family. Edward's mother describes 'living on pins for six years.
17 The issue of 'capacity' in Hampshire Constabulary charging decisions had the potential to cause confusion. This has been resolved by Operation Cavell.
18 The threats to steal money, steal money and damage property were not seen by agencies as economic domestic abuse.

9.Recommendations

9.1 Advice to be sought from the Home Office on the effectiveness of DASH as a risk checklist in cases where an adult child poses a threat to a parent.

9.2 That Southampton Local Authority harnesses the powerful messages expressed by this family concerning the impact the tragedy has had on them and their hopes for how families like theirs might be better helped in the future by working with them to produce a short video to be used by all agencies in their DA training for front line and associated workers.

9.3 That all agencies are explicit when risk assessing victims and family members about why an assessment is being undertaken and to be able to identify and evidence their assessment of the nature, level of seriousness and imminence of the risk they believe exists. If professionals believe victims to be minimising the risk posed by a family member, they should use their professional judgement to make HRDA referral in line with learning from the Standing Together research.

9.4 That Southern Health NHS Foundation Trust review the format of its SI's to reflect the whole person and does not frame the individual purely by any negative, criminal, or anti-social behaviour or other discriminatory identifiers.

9.5 That Southern Health NHS Foundation Trust review its 'Carers Strategy' to ensure that initial Psychiatric assessments are shared and communicated with the wider family where possible while working with and in event of serious events involving their family or the patient/client. This is in line with recent findings in the Domestic Homicide Project Spotlight Briefing #1: Adult Family Homicides Research January 2022 referred to earlier in this Review. Additionally, that in this, and in all future such cases to allocate an identified SPOC so that the family members can be communicated with sensitively and compassionately and to reduce re-traumatisation due to having to repeat their circumstances and background each time they speak to a member of staff.

9.6 That Southern Health NHS Foundation Trust ensure a distressed caller receives a follow up call or if not operationally possible a signposting to an appropriate agency at the time and that they secure a separate and confirmed assurance that the distressed caller has support from family or friends.

9.7 Commissioners of services to require as a condition of contract an assurance that such services offered are fit for purpose for this group of service users with mental health needs. And that the additional vulnerabilities of both client and carers and linked risks of domestic abuse are recognised and factored into any contract agreement, with a protocol (or agreed terms in the contract) in place to

ensure service providers accept and respond to their duty to help to protect potential victims.

9.8 All Health organisations' Domestic Abuse Policies need to be embedded in practice and relate to staff as well as patients. This must go beyond intimate partner abuse, which is generally recognised but also to include intra familial violence, which as research and this specific case shows is not so well recognised or even known of. DA 'complexities' training should be mandatory for all grades of staff, and it should follow the 'NICE' guidelines. All frontline staff should be expected to sensitively enquire about DA, including the identification of potential perpetrators and any risks they may pose to carers and/or other family members. If risks have been identified, safety planning must follow. Information sharing within an integrated care pathway should support this. This should be a standard item in both clinical and safeguarding supervision.

9.9 The Safer Cities Board and SSAB in light of this case review agency cohesion and joint working in the Southampton area. The Review heard of a complex landscape of agencies and Health bodies with often difficult and fractured lines of communication, a commitment should be made to undertake regular multi-agency audits of cases. This to be a shared venture with representatives from all relevant agencies participating and sharing information and recommendations from the learning. The learning from these audits to be shared with all relevant staff and stakeholders.

9.10 That all agencies in Southampton to have an action Plan in place to prepare for the introduction and need to implement the Domestic Abuse Act 2021. That this action plan includes a policy and process on the risk assessment and management of domestic abuse. This is a wide-ranging act which will have consequences for many agencies both within and outside of the DA sector. This will include many new duties to collect, store and share information and will require modification to current rules and methods of information storing and sharing.

9.11 This recommendation builds on the Southampton wide Carers Strategy which has been developed in an ongoing partnership with carers and whose governance sits with the Better Care Board (under the Health and Wellbeing Board).

I. The Better Care Board (Health and Wellbeing Board) is assured that the staff (paid or unpaid) across the city can identify carers and know how to respond to their safety, wellbeing, and support needs, including sharing information with relevant services where this is needed.

II. That the Southampton wide Carers Strategy includes an emphasis on carers and safeguarding, a focus on both the carer and the adult they care for, including why carers may be at risk of harm and what may prevent, reduce or stop the risk. The learning within the recent Carers and safeguarding: a briefing for people who work with carers | Local Government Association would support this.

III. To support the effective safeguarding of carers the strategy should also include a link to guidance for frontline workers in speaking privately with carers, using an agreed list of questions that cover issues of coping, fear, threat and safety to ensure proper assessment and response to any identified areas of concern.

IV. The 4LSAB Family Approach is due for revision and should be relaunched with a focus on identifying risk and needs of carers as well as adults with care and support needs. This includes an expectation of using the Multi Agency Risk Management framework and any other multi-agency forums for the management of any risks to carers/family members from the adult with care and support needs.

9.12 Southern Health Foundation Trust agree the safeguarding pathway they are currently (as of June 2022) reviewing. This will provide a streamlined procedure for responding to safeguarding concerns. Including finalising the safeguarding module on the Rio recording system which will enable them to record safeguarding concerns if the Section 42 threshold has been met and the outcome of the safeguarding concern.

9.13 That all front facing workers and managers receive training that enables them to identify risks posed to family and carers in non-intimate familial relationships and ensure all workers understand and appropriately assess the impact of known risk factors such as substance abuse and poor mental health which may increase risk to family members. The Panel accept that this is a long-term project which will involve a cultural shift in how workers see and approach their work with the client/patient. It is anticipated that achieving this shift will involve four steps; 1) Raising the awareness of workers to non-intimate familial violence/control, 2) sourcing or developing the training material and 3) Committing to, providing, and resourcing the training, and 4) Embedding and ensuring that the learning is being applied in practice through clinical supervision and evidence in casework files.

9.14 That the Authority request that the Home Office commission the development of a brief and user-friendly Domestic Abuse assessment tool that can be used for non-intimate partner and inter family violence and abuse with confidence.

9.15 That Southern Health NHS Foundation Trust will seek to move recording of events and the presentation of service users from one which is primarily clinical, and evidence based to one that also includes an assessment of that evidence.

9.16 That all GP's in the area are aware of and subscribe to the good practice identified in the Royal College of General Practice 2013 Policy document "Supporting carers in general practice: a framework of quality markers".

9.17 The CCG promote a consistent approach with Carers across the GP Surgeries they commission to include: -

- As a minimum all GP surgeries (if they do not already have in place) to develop a list of all patients who are also carers and to have a marker system so that such patients are identified automatically to both GP, reception and any other auxiliary nursing staff linked to the practice.
- To encourage all GPs in the area to develop a process to actively identify, refer, and support carers including children and young people, to reduce or prevent inappropriate caring responsibilities, because of taking on caring roles.
- To ensure all GP's provide written advice to carers, including young carers, of their right to request a carer's needs assessment.
- To ensure carers are encouraged to book a separate appointment for themselves to discuss what matters to them, including their own health and wellbeing needs.

9.18 The SSAB and Southampton Safe City Partnership share all agencies assessment and management tools for when 'Threats to Kill' are made with a view to learning from each other and establishing what is best practice.

Appendix 1: Methodology for the overview report

Data analysis

The Panel discussed the chronology of events and draft recommendations in an inclusive and collaborative way, which involved all members in reflective learning. It was a generative process which encouraged us to ask the aspirational question – ‘what a safe system would look like?’ The outcomes from this process have formed the basis of the review recommendations. The recommendations were shared with Peter’s family prior to the review being completed to ensure her family were as involved in the outcomes as possible.

It must be acknowledged that any review opens anxieties, but it was the panel’s intention to create a culture of accountability and learning not of culpability or blame. The review panel were unanimous in wanting to value the actions and approaches that worked well, whilst facing the tough issues of what else could or should have been offered. This was to produce effective recommendations which seek to make others confronted by these complex situations safer.

The chair wished to adopt a ‘no surprises’ approach, to encourage meaningful discussion and to air differences of opinion. The draft overview report was circulated to the panel and marked Restricted. Until final comments were received the panel members had the right to share the draft report with those participating professionals and their line managers who have a pre-declared interest in the review.

The Home Office guidelines require the final report in full to remain RESTRICTED and must only be disseminated with the agreement of the Chair of the Domestic Homicide Review Panel.

Appendix 2: Terms of Reference

1. Introduction

This Domestic Homicide Review (DHR) was commissioned by the Southampton Safe City Partnership following the homicide of Peter in February 2020.

The key purpose of undertaking domestic homicide reviews (DHR) is to identify the lessons to be learnt from homicides in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse, or neglect by –

(a) a person to whom he was related or with whom he was or had been in an intimate personal relationship, or

(b) a member of the same household as himself

Domestic homicide reviews are not inquiries into how the victim died or who is culpable. In order for lessons to be learnt as widely and thoroughly as possible, professionals need to be able to understand fully what happened in each case, and most importantly, what needs to change in order to reduce the risk of such tragedies happening in the future.

The victim is understood to be the father of the perpetrator.

2. Purpose of the review

The purpose of the review is to:

- Establish the facts that led to the incident in February 2020 and whether there are any lessons to be learned from the case about the way in which professionals and agencies worked together to safeguard the family.

- Identify what those lessons are, how they will be acted upon and what is expected to change as a result.

- Apply these lessons to service responses including changes to policies and procedures as appropriate.

- Prevent domestic violence and abuse homicide and improve service responses for all domestic violence and abuse victims and their children through improved intra and inter-agency working.

- Establish the facts that led to the incident and whether there are any lessons to be learned from the case about the way in which local professionals and agencies worked together to support or manage the perpetrator.

Domestic Homicide Reviews are not inquiries into how the victim died or who is culpable. That is a matter for coroners and criminal courts.

3. Scope of the review

The review will:

Consider the period from Feb 2016 to February 2020 subject to any information emerging that prompts a review of any earlier incidents or events that are relevant.

Request Individual Management Reviews by each of the agencies defined in Section 9 of the Act and invite responses from any other relevant agencies or individuals identified through the process of the review.

Seek the involvement of the family, employers, neighbours & friends to provide a robust analysis of the events.

Take account of the coroners' inquest in terms of timing and contact with the family.

Produce a report which summarises the chronology of the events, including the actions of involved agencies, analysis and comments on the actions taken and makes any required recommendations regarding safeguarding of families and children where domestic abuse is a feature.

Aim to produce the report within six months after completion of the criminal proceedings, responding sensitively to the concerns of the family, particularly in relation to the inquest process, the individual management reviews being completed and the potential for identifying matters which may require further review.

In addition, the following areas will be addressed in the Individual Management Reviews and the Overview Report:

- Was the victim known to domestic abuse services, was the incident a one off or were there any warning signs. Could more be done to raise awareness of services available to victims of domestic abuse?

- Was the perpetrator known to domestic abuse services, was the incident a one off or were there any warning signs.

- Were there any barriers experienced by the victim or family, friends and colleagues in reporting the abuse.

- Where there any opportunities for professionals to routinely enquire as to any domestic abuse experienced by the victim that were missed?

- Are there any training or awareness raising requirements that are necessary to ensure a greater knowledge and understanding of the services available?

- Consider any equality and diversity issues that appear pertinent to the victim, and perpetrator.
- Was the alleged perpetrator known to have a history of DA, if so, what support was offered to the perpetrator?
- Were staff working with the alleged perpetrator confident around what service provision is available around DA locally?

4. Family involvement

The review will seek to involve the family of both the victim and the perpetrator in the review process, taking account of who the family wish to have involved as lead members and to identify other people they think relevant to the review process.

We will seek to agree a communication strategy that keeps the families informed, if they so wish, throughout the process. We will be sensitive to their wishes, their need for support and any existing arrangements that are in place to do this.

We will identify the timescale and process of the coroner's inquest and ensure that the family are able to respond to this review and the inquest avoiding duplication of effort and without undue pressure.

5. Legal advice and costs

Each statutory agency will be expected and reminded to inform their legal departments that the review is taking place. Each statutory agency may seek their own legal advice at their own discretion and cost.

6. Panel members, expert witnesses and advisors

The following agencies and individuals are suggested to participate in the review panel: See Appendix 1. At the time of drafting these Terms of Reference the Panel are confident its membership has specific expertise in domestic abuse but as the review progresses it may identify specific areas of expertise required and will seek this expertise if necessary.

7. Media and communication

The management of all media and communication matters will be through a joint team drawn from the statutory partners involved. There will be no presumption to inform the public via the media that a review is being held in order to protect the family from any unwanted media attention.

However, a reactive press statement regarding the review will be developed to respond to any enquiries to explain the basis for the review, why and who commissioned the review, the basic methodology and that the review is working closely with the family throughout the process. An executive summary of the review will be published on the CSP website, with an appropriate press statement available to respond to any enquiries.

The recommendations of the review will be distributed through the CSP website and applied to any other learning opportunities with partner agencies involved with responding to domestic abuse.

8. Data Protection Act 2018 and General Data Protection Regulations

A Personal Information Sharing Agreement has been produced to facilitate the exchange of personal information to meet the aims of a DHR and the requirements of data protection legislation.

Appendix 3: Glossary

Acronym	Explanation
MARM	A Multi-Agency Risk Management process where agencies meet to establish an agreed risk management plan
MARAC	A Multi-Agency Risk Assessment Conference a meeting to manage the risk related to high-risk domestic abuse cases
HRDA	High Risk Domestic Abuse process
MAPPA	Multi-Agency Public Protection Arrangements are in place in the UK to ensure the successful management of violent and sexual offenders.
AMHT	Adult Mental Health Team
EIP	Early Intervention Psychosis team

Appendix 4: Agency recommendations from IMRs

Single agency recommendations in the IMRs submitted to this Review.

1.	University Hospital Southampton NHS Trust (UHSFT)	1.To increase awareness regarding Professional curiosity - UHS have produced a learning briefing to be disseminated across UHS to highlight awareness of professional curiosity and respectful uncertainty. 2.To increase awareness of the 4LSAB family approach framework – The new Level 3 Safeguarding Adults Training at UHS is in development which incorporates this approach. The safeguarding team (adult and child) work in an integrated family approach within UHS. 3.The use of the 4LSAB MARM framework may have been a helpful tool between 2016 -2017 if high risks had been identified when Edward presented to UHS in mental health crisis – UHS has a dedicated MARM staffnet page. The Portsmouth SAB MARM podcast is also being shared throughout the Trust.
2	Solent NHS Trust	Amended September 2021 Solent NHS Trust will share learning identified in the DHR. DA training to be updated to include indicators of domestic abuse can include physical assault to staff members as well as family members.
3	Southern Health NHS Foundation Trust	1.To undertake further reflective practice

		2.Promote domestic abuse training and highlight the importance of information sharing and when it may be appropriate and proportionate to share information with other agencies.
4	Hampshire Constabulary	1.Hampshire Constabulary to expedite learning from other reviews to develop a clear policy and/or guidance to advise staff when it is appropriate to add warning markers to RMS and other relevant systems, specifically regarding mental health, vulnerabilities, self-harm and/or suicidal ideation. 2. Hampshire Constabulary should consider a focused internal communications campaign (with training) that sets out to officers and staff, with clear and robust instruction, that when making decisions relating the use or non-use of S'136 that risk assessment is clearly considered and recorded on RMS. 3. Hampshire Constabulary to ensure that within the DA Strategy there is consistent methodology to enable officers and staff to understand risk posed by offenders. This should also address non-intimate familial relationships and ensure officers understand and appropriately assess the impact of other factors such as substance abuse and mental health which may increase risk. 4. Hampshire Constabulary to ensure that the Adult at Risk Strategy is delivered in 2020-2021 and that subsequent training targets all frontline teams. This should include a focus on enabling officers and staff to have a greater understanding of mental capacity within the policing decision making and response. 5. The Hampshire Constabulary Learning and Development team devise a centralised training

		module on THOR to assist with force wide understanding and consistency in its application. Recommendation 6: Hampshire Constabulary initiate the 'Ex-Dom' pilot and evaluate the findings by spring 2021.
5	Southampton CCG on behalf of Primary Care	There are not urgent immediate actions required. Points for us to reflect on and smart outcomes to follow: 1.Increased awareness of carers so their support needs are understood and addressed. Who are they caring for, and whether there are any specific needs as not all carers are doing the same 'work'? 2.How we can improve engagement with health checks in primary care for those with chronic mental health problems.
6	Adult Social Care, Southampton City Council	1.All the involvement of the AMHP Team and ASCC took place before May 2017. This was approximately two and a half years before the homicide in February 2020, so there are no meaningful conclusions or recommendations about events that may have had bearing on the homicide. SCC records about Peter are minimal, so I cannot make recommendations or indicate any lessons that could be learned. 2.That in the development of the recording template for the future SCC Care recording system, Care Director, there is consideration of developments to the AMPH MHAA recording template to have a more

		specific and focussed section that asks questions about whether there are any identified risks to any of the people involved in the assessment process. This would include direct reference to Care Act Safeguarding duties. 3.The AMPH Team are having a Safeguarding Training seminar in late April. Identification of Risk and potential Safeguarding concerns that are secondary to their MHAA role will be included in this seminar.
7	SCC Homelessness (Shared)	None
	Integrated Commissioning Unit (CCG and SCC) _	Commissioners of services are, able to identify additional vulnerabilities of both clients and carers linked to DA and able to respond appropriately and help protect potential victims.

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[i] The Resolution Centre is a dept. made up of staff and officers – they are tasked with resolving low risk and low harm crimes and non-crime occurrences.