Safer Gloucestershire Partnership

DHR Linda and Richard March 2022

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Parminder Sahota: Independent Chair and Author

Approved by Safer Gloucestershire - April 2023

Approved by Home Office Quality Assurance - November 2023

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Preface

The Independent Chair and Review Panel send their deepest condolences to all those impacted by Linda and Richard's untimely passing and thank them for their involvement and support in this process.

The primary objective of a Domestic Homicide Review (DHR) is to permit the learning of lessons from the death of a person(s) in a relationship where domestic abuse was known to have occurred. Professionals must understand what transpired in each situation for these lessons to be thoroughly and effectively digested. What must be modified most to lessen the likelihood of such tragedies?

The chair thanks the panel and persons who submitted chronologies and materials for their time and cooperation.

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Section One – The Review Process

1.1 Introduction and Agencies Participating in the Review

1.1.1 This summary describes the steps the Gloucestershire Domestic Homicide Review Panel took to review two residents' deaths. The deaths occurred in March 2022.

1.1.2 Linda, a 73-year-old white British female, and Richard, a 67-year-old white British male, were the victims. Their deaths were caused by their son, Adult A.

1.1.3 On 22 March 2022, following the Multi-Agency Statutory Guidance for Domestic Homicide Reviews (2016), the Safer Gloucestershire Partnership commissioned a domestic homicide review.

1.1.4 The independent chair was commissioned on 6 April 2022. Safer Gloucestershire Partnership approved the completed report on 17th April 2023.

1.1.5 The panel convened for the first time with the chair on 20 July 2022.

1.1.6 On 22 February 2023, the review panel's final meeting was held. To complete the report and conclusions, consider the necessary steps to implement the recommendations and finalise the report.

1.1.7 Due to the number of current reviews in the county and the necessity to balance agency demand, the procedure took longer than the six-month deadline stated in the statutory guidance.

1.1.8 Safer Gloucestershire notified the family and invited them via letter to participate in the review on 25 April 2022. As a result, victim Support appointed a Homicide Case Worker to the family. The chair contacted the worker multiple times to request family communication.

1.1.9 On 23 January 2023, the Chair communicated with a son after he initiated communication. He gave the Chair the background information for Linda and requested a report copy.

1.1.10 The following individuals and agencies contributed to the review; the individuals are independent and do not work directly with Linda, Richard or the wider family.

Name	Role	Organisation
Andy Barge	Group Manager for Communities	Cotswold District Council
Angela Claridge	Director of Governance	Cotswold District Council
Ann Thummler	Named Lead for Safeguarding Adults	Gloucestershire Health and Care NHS Trust
Jeanette Welsh	Lead for Safeguarding Adults	Gloucestershire Hospitals NHS Foundation Trust

Sam O'Mally	Safeguarding	Integrated Care Board – Representing the GP Practices
Paul Tuckey	Housing Options Manager	Cheltenham Borough Homes
Rory Ainslie	Detective Inspector	Gloucestershire Constabulary
Sophie Jarrett	County Domestic Abuse and Sexual Violence Strategic Coordinator	Gloucestershire Constabulary and Gloucestershire County Council
Tessa Davis	Manager	Gloucestershire Domestic Abuse Support Service
Tracey Brown	Safeguarding and Partnership Manager	Cheltenham Borough Council
Parminder Sahota	Independent Chair/Author	PS. Safeguarding LTD

1.1.11 Parminder Sahota is an independent author with ten years of experience in domestic abuse and safeguarding. Advocacy After Fatal Abuse provided the DHR Chair training in 2021. She has worked as a mental health nurse in the NHS for over 20 years. She is a Director of Safeguarding, Prevent, and Domestic Abuse Lead for an NHS Trust.

1.1.12 Parminder Sahota is independent of all agencies involved and had no prior contact with family members or the Safer Gloucestershire Partnership.

1.2 Purpose and Terms of Reference: Key Lines of Enquiry

1.2.1 The statutory guidance sets out the purpose of domestic homicide reviews to:

- Establish the facts that led to the deaths in March 2022 and whether any lessons can be learned from the case about how local professionals and agencies worked together to safeguard Linda and Richard.
- Establish what lessons will be learned from the deaths regarding how local professionals and organisations work individually and together to safeguard victims.
- Identify these lessons, both within and between agencies, how and within what timescales they will be acted on, and what is expected to change.
- Apply these lessons to service responses, including changes to inform appropriate national and local policies and procedures.
- Prevent domestic violence and related deaths and improve service responses for all domestic violence and abuse victims by developing a coordinated multi-agency approach to identify and respond to domestic abuse at the earliest opportunity.
- Contribute to a better understanding of the nature of domestic abuse.
- Highlight good practice.
- Ensure that Linda and Richard's voices are heard regarding their lived experiences and the impact of the domestic abuse on their mental health. Allowing their journey to be told and identifying the lessons that may be learnt.

1.2.2 The panel members and advisors were all chosen by the review panel. The review's time frame was set to cover the months of August 2020 to March 2022. The panel agreed that this time frame accurately reflected the difficulties discovered during scoping and subsequent communication with agencies.

1.2.3 The panel agreed on which agencies must submit a comprehensive chronology and individual management review per Section 9 of the Domestic Violence, Crime and Victims Act 2004 (Revised 2016).

1.2.4 The panel agreed on seventeen Key Lines of Enquiry for this case.

Section Two – Agency contact and information learned from the review.

2.1 Linda received input from the following agencies during the period under review:

1. GP Practice
2. Gloucestershire Health and Care NHS Trust

2.2 Richard received input from the following agencies during the period under review:

1) Gloucestershire Health and Care NHS Trust

2.3 Linda was the mother of seven children, three from her previous marriage and four from her relationship with Richard. After 25 years of marriage, Linda and Richard divorced in 2012 and lived in separate homes. Adult A was the eldest son of Linda and Richard.

2.4 Linda reported Adult A to the police in December 2020 after he assaulted her physically. He was arrested, and a restraining order was issued against him.

2.5 Linda called Gloucestershire Health and Care Trust multiple times in January 2022 to request assistance for Adult A, whom she felt was experiencing poor mental health. She was urged to request that Adult A communicate directly with them or his GP.

2.6 Adult A allegedly threatened to murder his housemate, resulting in an altercation. A call to the police resulted in Adult A's arrest. On 19 February 2022, in response to mental health concerns, he was assessed under the Mental Health Act (1983), held under Section 2, and admitted to a mental health unit.

2.7 Linda and Adult A's siblings called the hospital concerned about Adult A's mental health. Including emails with subject lines such as "I'm taking you down" and "Burn in hell." In addition, he inserted a screenshot from the film "Two on the Guillotine."

2.8 Adult A was permitted escorted leave with a hospital staff member and unescorted leave in the hospital courtyard from where he absconded; he then withdrew £100 and did not return to the hospital. He was afterwards granted unaccompanied ground leave and did not return. At midnight, Adult A's absence was reported to the police. The following morning, his mother and father were found deceased.

2.9 Evidence of Domestic Abuse

2.10 5 December 2020, following Adult A's physical assault, Linda notified the police.

2.11 30 October 2021, Linda reported concerns to Gloucestershire Health and Care Trust concerning Adult A's cannabis use and not taking his anti-psychotic and anti-depressant medication. Adult A believed that Linda wanted to kill him through gaslighting and that she murdered his father. She thought he felt harassed by her and had moved out of the family home into a house she owned, which was a house of multiple occupancy.

2.12 16 January 2022, Linda informed the Gloucestershire Health and Care Trust that Adult A was deteriorating and had damaged the rental property. Another tenant had stated Adult A had "lost the plot." Linda was instructed to phone the police if she or others felt threatened. Adult A was angry because Linda had called the ambulance without informing him.

2.13 10 February 2022, Adult A referred to Linda as a "narcissist" and was "vindictive" toward him for calling the ambulance and police for no apparent reason. He felt Linda was bringing him down.

2.14 Linda notified the police on 14 February 2022 that she intended to request Adult A's departure.

2.15 Linda reported to the Gloucestershire Health and Care Trust on 15 February 2022 that Adult A had injured a tenant and verbally abused her.

2.16 16 February 2022, Linda disclosed to the Gloucestershire Health and Care Trust and her GP that she was terrified of Adult A.

2.17 18 February 2022, Adult A's bail restrictions prohibited him from contacting his mother. As a result, Adult A was admitted to a mental health ward.

2.18 February 2022, Adult A believed his mother was to blame for his admission.

2.19 February 2022, Adult A believed his mother was responsible for his admission.

2.20 February 2022, Adult A sent abusive emails to his siblings and family with headings "burn in hell" and "I'm taking you down".

Section Three – Key Issues arising from the review

3.1 Routine Enquiry and Response to Domestic Abuse

3.2 After Adult A assaulted Linda in December 2020, she contacted the police, who referred her to domestic abuse services. The assault was communicated to the GP by the ambulance service. Linda informed her GP that she had been referred to domestic abuse services.

3.3 Gloucestershire Health and Care Trust accepted that they did not identify domestic abuse during their interactions with Linda and did not ask Richard about it during their work with him. However, the GP review author stated that a risk assessment should have been undertaken after learning that Linda feared Adult A.

3.4 **Information Sharing**

3.5 According to Gloucestershire Health and Care Trust, their response was impeded by the necessity for permission to divulge information. In addition, this should have encouraged them to call Adult A or share their concerns with his GP.

3.6 The GP was aware that Linda had attempted to receive support through Gloucestershire Health and Care Trust; thus, the GP may have contacted the Trust to discuss how they could assist Linda. In addition, Adult A's GP also engaged in safeguarding sessions at the GP Practice and had contact with Adult A in July 2021. Consequently, it is possible to conclude that they were aware of the issues.

3.7 The Gloucestershire Health and Care Trust and GP Practice were aware of Linda's concerns regarding Adult A. However, they did not communicate with one another.

3.8 **Familial Abuse**

3.9 Linda experienced adult family abuse at her son's hands, for whom she provided informal care due to his mental illness.

3.10 According to the DHR, Adult A abused Linda several times; however, only one incident was reported to the police. Although domestic abuse services, which received the first referral, were unaware of the initial instance, a multi-agency response would have been necessary if they had been made aware of them.

3.11 According to the panel, Gloucestershire Health and Care Trust and the GP might have used a risk assessment to highlight the issues, to be better informed about the risks, and to ensure enough resources were available to protect Linda and respond to her concerns about Adult A.

3.12 Other family members (Adult A's brother and sister) had also received threatening and abusive communication from Adult A, according to the Gloucestershire Health and Care Trust. The ward staff was informed, but no action was taken.

Section Four – Recommendations

Individual IMR Recommendations

4.1 Gloucestershire Health and Care NHS Foundation Trust (GHC)

1. Cheltenham Lane Centre (CLC), Community Mental Health Team (CMHT) and all clinical trust staff must be reminded of our Consultant Nurse in Dual Diagnosis role and referral protocol to CGL where substance misuse is linked with an SMI.

2. CLC, CMHT, and all clinical trust staff are to be reminded of our Veteran's Pathway, GHC Veteran experts, and signposting options.

3. GHC should consider timely information sharing of deaths and serious incidents with still-involved staff where possible.

4.2 GP Practice

1. The Practice to develop DA Champions and Safe Spaces by engaging with the GDASS Health Champions programme. GDASS encourages all surgeries to sign up for our Safe Space scheme – this means the surgery has been trained in Recognising and Responding to DA, has an active champion, and actively displays information on DA – including GDASS posters and leaflets.

Recommendations for the panel

4.3 Recommendation one: Professional Curiosity

The Gloucestershire Safeguarding Children Executive, has published a professional curiosity-related practice brief.

1. a. For the CSP to review the brief and extend this to strengthen and cultivate professional curiosity around their practice with adults.

1. b. The brief must be evaluated, and measures put in place to assess its impact, including feedback from staff and service users on its utilisation.

4.4 Recommendation Two for Health: Routine Enquiry and Response to Domestic Abuse.

Linda reported domestic abuse to Gloucestershire Health and Care Trust, her GP, and the police. As a result, Linda was referred to domestic abuse services after the police performed a risk assessment. As a result, the perpetrator of domestic abuse towards his mother, Adult A, was issued a restraining order. Following Adult A's arrest in February 2022, he was on bail and admitted to the mental health unit with the condition that he does not contact Linda.

2.a. Responding to domestic abuse is the responsibility of everyone. To enable agencies to fulfil their duties effectively, all staff must acquire the training to identify victims/survivors and ensure they receive the appropriate support. This would entail adopting procedures for information sharing and effective methods for recording and referring victims/survivors to the proper services. Agencies must be capable of extracting the required data to ensure compliance with this requirement.

2. b. Health service policies and procedures include the NICE Quality Standard (QS116). Therefore, the staff should be able to enquire about and respond to disclosures of domestic abuse.

2. c. For agencies to ensure they have an easily accessible system for practitioners to refer domestic abuse victims to resources and a process to provide, the domestic abuse discussion is documented.

2. d. Services to assess what technology is now available to facilitate routine enquiry.

4.5 Recommendation Three for Health: Information Sharing.

Gloucestershire Health and Care Trust were concerned about the consent required from Adult A, which prevented them from providing Linda with the necessary support and communicating her concern with Adult A's GP. The GP had an excellent relationship with Linda, who felt at ease discussing her concerns. However, the GP did not discuss these concerns with the appropriate agencies because they thought the Domestic Abuse Service was involved and may have assumed they were already cited.

3.a. Agencies must ensure that the Caldicott Guardian Decision-Making Template is included in their information-sharing protocols.

3. b. Agencies should review their present training on information governance and ensure that all staff are required to attend, as well as be aware of the instances in which they can overturn consent. In addition, they should have procedures to assist practitioners in doing so following GDPR article six.

4.6 Recommendation Four: Familial Abuse

Due to the deaths of Linda and Richard at the hands of their son, Adult A, the DHR was commissioned. Adult A had engaged in domestic abuse towards Linda.

4.a. The Gloucestershire Domestic Abuse Local Partnership Board should ensure that the conclusions of this review, particularly those about Child-to-Parent Abuse, are considered when they assess the local training pathway. This will ensure that professional training to raise understanding of familial abuse is considered in any training commissioning activity, allowing agencies to recognise familial abuse and respond more effectively.

4. b. The Gloucestershire Domestic Abuse Local Partnership Board must ensure that the findings of this evaluation about adult child-on-parent abuse are incorporated into their ongoing efforts to examine best practices and build local approaches to familial abuse.

4. c The Gloucestershire Domestic Abuse Local Partnership Board to review available risk assessment tools when responding to familial domestic abuse and circulate best practice approaches to the wider partnership. This should include the Think Family Safeguarding approach to consider additional family members who may also be victims and the “main" victim. The risk assessment also incorporates the risk variables outlined by Standing Together: mental health, substance abuse, caring relationships, aggression towards partners and other family members, and further instability characteristics.

4.14 Recommendation Five: DASH Risk Assessment.

For a national evaluation of the DASH risk assessment for domestic abuse, familial abuse and learning disabilities.

Section five – Conclusions

5.1 Linda was 73 years old and worked as a hospital trust medical secretary and property owner. Linda was divorced from her husband Richard of twenty-five years and had seven children, including Adult A.

5.2 Richard was 67 years old and a veteran at his death. His most recent contact with mental health professionals was in January 2022, and he revealed that he was doing well, had quit consuming cannabis, and felt "great." However, because Richard had limited engagement with his GP and Gloucestershire Hospital, his voice could only be heard through Gloucestershire Health and Care Trust, emphasising his relationship with Gloucestershire Health and Care Trust.

5.3 Linda and Richard's deaths shook their respective communities, family, friends, co-workers, and professionals who worked with them. The killings had an impact on the panel as well. The chair advised each member to ensure they had adequate support networks and to communicate with their supervisor/manager/colleague without jeopardising confidentiality.

5.4 The review has focused particularly on Linda, partly because of her informal and unrecognised role as Adult As' carer, her attempts to gain help for him, and her experience as a victim of domestic abuse. Richard had informed Gloucestershire Health and Care Trust that he was estranged from Adult A, and the agency's records show no contact between them. Furthermore, Richard had not reported any concerns about domestic abuse, and agencies working with Richard did not question him about it.

5.5 Gloucestershire Health and Care Trust have concluded its review of the incident involving Adult A.

5.6 The reports will be shared with Linda's son and daughter, and the lessons learned will be shared with the agencies engaged in the review.