SEFTON SAFER COMMUNITIES PARTNERSHIP

DOMESTIC HOMICIDE REVIEW

'Charles'

Died Spring 2019

OVERVIEW REPORT

FOR PUBLICATION

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Supported by Carol Ellwood-Clarke QPM

CONTENTS

1. INTRODUCTION

1.1 This report of a Domestic Homicide Review[1] [DHR] examines whether agencies could have identified if Charles, a resident at address 1 in Sefton, was at risk from his son Thomas. On a Sunday in early spring 2019, Charles and his wife Janette returned from church. Charles asked Thomas for some money. There was an argument and Thomas punched his father to the body and face.

1.2 The following day Charles was seen by a doctor who treated him at home and submitted a safeguarding alert. The following Wednesday a member of the public [who remains anonymous] contacted Merseyside Police with concerns for Charles. Officers attended and an ambulance was called. Charles was conveyed to hospital and Thomas was arrested on suspicion of assault. He was later convicted of assaulting his father.

1.3 Two weeks later, and before Thomas was sentenced, Charles died in hospital from injuries that were the direct result of the assault. Thomas was re-arrested and charged with the manslaughter of his father. He pleaded guilty and was sentenced to a term of 3 years and 4 months imprisonment.

1.4 In addition to agency involvement the review will also examine the past to identify any relevant background or trail of abuse before the homicide, whether support was accessed within the community and whether there were any barriers to accessing support. By taking a holistic approach, the review seeks to identify appropriate solutions to make the future safer[2].

1.5 The key purpose for undertaking domestic homicide reviews is to enable lessons to be learned from homicides where a person is killed as a result of domestic abuse. In order 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 in order to reduce the risk of such tragedies happening in the future.

1.6 The DHR panel extend their condolences to Charles' wife on her loss and for the consequences to her of this tragic event.

[1] Section 4 of this report sets out in more detail the purpose of a DHR and the terms of reference the review panel adopted.
[2] Home Office Guidance Domestic Homicide Reviews December 2016.

2. CONFIDENTIALITY

2.1 Until the report is published it is marked: Official Sensitive Government Security Classifications May 2018.

2.2 The names of any key individuals involved in the review are disguised using an agreed pseudonym which were chosen by the family.

2.3 This table shows the age and ethnicity of the victim, the perpetrator of the homicide and other key individuals.

Name	Relationship	Age	Ethnicity
Charles	Victim	90	White British
Thomas	Perpetrator	20	White British
Janette	Wife of Victim	59	White British
Anna	Daughter of Janette	31	White British
Sarah	Girlfriend of Thomas	21	White British
Address 1	Home of Charles, Janette and Thomas	Scene of assault	

3. TERMS OF REFERENCE

3.1 The Panel settled on the following terms of reference at its first meeting on 29 November 2019. They were shared in a letter with Anna [see paragraph 5.1].

3.2 The review covers the period from 6 April 2017 to a day in Spring 2019 when Charles died. The start date approximated to the date of Charles registration with his most recent GP practice.

The purpose of a Domestic Homicide Review [DHR][3]

a] Establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims.

b] Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result.

c] Apply these lessons to service responses including changes to inform national and local policies and procedures as appropriate.

d] Prevent domestic violence and homicide and improve service responses for all domestic violence and abuse victims and their children by developing a co-ordinated multi-agency approach to ensure that domestic violence and abuse is identified and responded to effectively at the earliest opportunity.

e] Contribute to a better understanding of the nature of domestic violence and abuse; and

f] Highlight good practice.

Specific Terms

1. What indicators of domestic abuse, including coercive and controlling behaviour, did your agency have that could have identified Charles as a victim of domestic abuse and what was your response.

2. What risk assessments did your agency undertake for Charles or Thomas; what was the outcome and if you provided services were they fit for purpose? Did Charles have any known vulnerabilities and was he in receipt of any services or support for these?

[3] Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews [2016] Section 2 Paragraph 7

3. What was your agency's knowledge of any barriers faced by Charles that might have prevented him reporting domestic abuse and what did it do to overcome them?

4. What knowledge did your agency have of Charles' and Thomas' physical and mental health needs and what services did you provide? Was Thomas living with Asperger syndrome or any other diagnosed condition?

5. What knowledge or concerns did the victim's family, friends, colleagues and wider community have about Charles' victimisation and did they know what to do with it?

6. What knowledge did your agency have that indicated Thomas might be a perpetrator of domestic abuse and what was the response, including any referrals to a Multi-Agency Risk Assessment Conference [MARAC]?

7. How did your agency take account of any racial, cultural, linguistic, faith or other diversity issues, when completing assessments and providing services to Charles and Thomas? Were they members of any faith communities and if so does that community have any information that may be of relevance to the DHR?

8. Was debt, finance, alcohol or substance misuse an issue that was a relevant factor in relation to this DHR?

9. Did your agency follow its domestic abuse policy and procedures, and the multi-agency ones?

10. Were there issues in relation to capacity or resources in your agency that impacted on its ability to provide services to Charles and Thomas, or on your agency's ability to work effectively with other agencies?

11. What learning has emerged for your agency?

12. Are there any examples of outstanding or innovative practice arising from this case?

13. Does the learning in this review appear in other Domestic Homicide Reviews commissioned by Sefton Community Safety Partnership?

4. METHOD AND TIMESCALES

4.1 Merseyside Police notified Sefton Safer Communities Partnership of the manslaughter of Charles. The Partnership wrote letters to all agencies in their area requesting they secure their files and provide chronologies of their contact with Charles and Thomas.

4.2 On 18 September 2019 the Chair of Sefton Safer Communities Partnership determined the case met the criteria for a domestic homicide review [DHR]. The Home Office were informed of the decision.

4.3 Paul Cheeseman was appointed as the independent Chair and author on 25 September 2019. The first panel meeting was held on 29 November 2019. The review panel determined which agencies were required to submit written information and in what format.

4.4 The DHR panel carefully considered the material provided by agencies and the contributions made by the family of Charles [see section 5 post] to establish what it told them about his life and his relationship with Thomas. The panel identified a number of issues and learning points for agencies which are considered in detail within section 15 of this report.

4.5 The panel held three meetings before the Covid 19 Crisis began. By this time a draft report was available for the panel who were not able to hold any face-to-face meetings because of government restrictions and advice. Instead the report was circulated by e mail and panel members were asked to submit written comments. A virtual meeting was then held by Skype and telephone during which the panel identified lessons, recommendations and some further work that was needed. This work was undertaken and the report amended before again being circulated electronically for panel members comments.

5. INVOLVEMENT OF FAMILY

5.1 Because Janette was unwell, the DHR Chair wrote in the first instance to her daughter Anna. He asked Anna to speak to her mother and assess whether she was well enough, and felt able, to contribute to the review. The Chair included within the letter a draft of the terms of reference, the Home Office domestic homicide leaflet for families and the Advocacy After Fatal Domestic Abuse (AAFDA) leaflet. Anna shared this information with her mother.

5.2 Anna agreed to be the main family point of contact for the DHR and provided much of the background information. The Chair had an initial meeting with Anna on Tuesday 18 February 2020. They discussed the terms of reference and Anna was again invited to make any suggestions she felt were necessary. Anna said she was content with them.

5.3 The Chair maintained contact with Anna throughout the Covid 19 crisis and explained how the panel would try and make progress with the review. A meeting the Chair planned to hold with Anna and Janette was also cancelled because of the Covid 19 crisis.

5.4 Anna and the Chair agreed that a Skype meeting was unlikely to be productive because of Janette's condition. Instead, as Anna was able to have 1:1 social distancing contact with Janette, the Chair asked her to discuss the report with her mother and seek any comments or view she was able to provide. Because of Covid 19 neither was it possible to facilitate a face-to-face meeting between Anna and the DHR panel. However, any questions or queries raised by Anna were discussed with the panel during the Skype meeting and electronic contact.

5.5 Charles's siblings are all deceased and the DHR panel were not able to identify any close relatives on his side of the family. The only voice of the victim has been through a short statement taken by the police before he died in relation to what happened on the day. Although Charles confirmed he would provide more information at a later date he sadly died before he was able to do so. The panel feel it is important that readers of this report recognise this may have led to an imbalance within the report between the limited information from Charles, compared to the more extensive and sometimes critical view of him provided by others. The panel feel it is important to stress that, while it has not been possible to remove this imbalance because of the weight of testimony, Charles is and always will remain the victim of this domestic homicide no matter how aggrieved others may feel.

5.6 The Chair wrote to Thomas in prison to ask him if he wished to contribute to the review. He did not receive a response and because of the Covid 19 crisis it meant it would not have been possible to visit the prison and meet with him anyway. The Chair considered whether it might be possible for him to speak to Thomas by telephone. After discussing the issue with Anna the Chair agreed with her that, given Thomas' learning difficulties, such an approach might be detrimental to his wellbeing and therefore the Chair did not contact him. Instead it was agreed that Anna [who has maintained regular contact with her brother] would speak to Thomas about the DHR when she received the draft report and see if he had anything he wished to contribute.

5.7 When the panel completed work on the report it was sent to Anna as the family representative for contribution and comment. Anna made a number of helpful comments and suggestions concerning the report. These have been included within the final version of the report at the appropriate place.

5.8 Anna confirmed to the Chair that she had discussed the report with both Janette and Thomas. However, neither of them had any comments to make.

6. CONTRIBUTORS TO THE REVIEW.

6.1 Thirteen agencies in Sefton were asked to secure and search their records for information. Only a small number of agencies had records of any contact with either Charles or Thomas. This table show the agencies who provided information relevant to the review.

Agency	IMR[4]	Chronology	Report
Merseyside Police	Yes	Yes	
GP Surgery	Yes	Yes	
North West Boroughs Health Care NHS Foundation Trust	Yes	Yes	
Aintree University Hospital NHS Foundation Trust			Yes
Sefton Adult Social Care	Yes	Yes	
Merseyside Fire & Rescue Service			Yes
OVH Association			Yes
Sefton Women and Children's Aid [SWACA]			Yes

6.2 The authors of the Individual Management Reviews included in them a statement of their independence from any operational or management responsibility for the matters under examination.

[4] Individual Management Review: a templated document setting out the agency's involvement with the subjects of the review which includes a chronology.

7. THE REVIEW PANEL MEMBERS

7.1 This table shows the review panel members.

Review Panel Members		
Name	**Job Title**	**Organisation**
Steve Bentley	Detective Sergeant	Merseyside Police
Paul Cheeseman	Chair	Independent
Carol Ellwood-Clarke QPM	Support to Chair	Independent
Neil Frackelton	Chief Executive	Sefton Women's and Children's Aid [SWACA]
Natalie Hendry-Torrance	Designated Safeguarding Adult Manager	South Sefton CCG and Southport and Formby CCG.
Neil Jones	Detective Constable	Merseyside Police
Angela Lacy	Head of Safeguarding	Merseycare NHS Foundation Trust
Janette Maxwell	Localities Team Manager	Sefton Council
Lynn McNiven	Detective Sergeant Public Protection Unit	Merseyside Police

7.2 The Chair of Sefton Community Safety Partnership was satisfied the panel Chair was independent. In turn, the panel Chair believed there was sufficient independence and expertise on the panel to safely and impartially examine the events and prepare an unbiased report. Outside of the meetings the Chair's queries were answered promptly and in full.

7.3 The review recognised at an early stage that specialist support to the panel would be helpful in relation to areas such as the elderly and autism. The localities team manager approached agencies that provided support in those specialist areas. Unfortunately, while the initial discussions were positive and there was a commitment to support the work of the review, the impact of the Covid 19 pandemic meant neither agency was able to engage further with the panel. While the review recognised this was a gap, having delayed the completion of the review already, the Chair felt it would be unfair to the family to further delay work on the review while awaiting a response from these

organisations. He therefore made the decision to proceed with further panel meetings without their input and to finalise the report.

8. CHAIR AND AUTHOR OF THE OVERVIEW REPORT

8.1 Sections 36 to 39 of the Home Office Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews December 2016 sets out the requirements for review Chairs and authors. In this case the Chair and author were the same person.

8.2 The Chair completed thirty-five years in public service [British policing and associated roles] retiring from full time work in 2014. He has undertaken the following types of reviews: Child Serious Case Reviews, Safeguarding Adult Reviews, Multi-Agency Public Protection Arrangements [MAPPA] Serious Case Reviews and Domestic Homicide Reviews. Carol Ellwood-Clarke QPM has a similar professional background to the Chair retiring from full time work in 2017.

8.3 Neither the Chair nor Carol Ellwood-Clarke QPM have worked for any agency providing information to this review. The Chair has worked on previous DHR reviews in Sefton the last one being in 2016.

9. PARALLEL REVIEWS

9.1 Her Majesty's Coroner for Sefton opened and adjourned an inquest into Charles' manslaughter. The Chair wrote to the Coroner informing him that a DHR was underway.

9.2 Merseyside Police completed a criminal investigation and prepared a case for the Crown Prosecution Service and court.

9.3 This case has been considered for a Safeguarding Adults Review (SAR) by Merseyside Safeguarding Adults Board. They have agreed a thematic review across 11 Merseyside cases looking at issues in relation to domestic abuse, neglect and carers. The learning will also be shared with the Merseyside Community Safety Partnerships.

9.4 The panel are not aware that any other agency is undertaking reviews connected with the manslaughter of Charles.

10. EQUALITY AND DIVERSITY

10.1 Section 4 of the Equality Act 2010 defines protective characteristics as:

- **age** [for example an age group would include "over fifties" or twenty-one-year-olds. A person aged twenty-one does not share the same characteristic of age with "people in their forties". However, a person aged twenty-one and people in their forties can share the characteristic of being in the "under fifty" age range].
- **disability** [for example a man works in a warehouse, loading and unloading heavy stock. He develops a long-term heart condition and no longer has the ability to lift or move heavy items of stock at work. Lifting and moving such heavy items is not a normal day-to-day activity. However, he is also unable to lift, carry or move moderately heavy everyday objects such as chairs, at work or around the home. This is an adverse effect on a normal day-to-day activity. He is likely to be considered a disabled person for the purposes of the Act].
- **gender reassignment** [for example a person who was born physically female decides to spend the rest of her life as a man. He starts and continues to live as a man. He decides not to seek medical advice as he successfully 'passes' as a man without the need for any medical intervention. He would have the protected characteristic of gender reassignment for the purposes of the Act].
- **marriage and civil partnership** [for example a person who is engaged to be married is not married and therefore does not have this protected characteristic. A divorcee or a person whose civil partnership has been dissolved is not married or in a civil partnership and therefore does not have this protected characteristic].
- **pregnancy and maternity**
- **race** [for example colour includes being black or white. Nationality includes being a British, Australian or Swiss citizen. Ethnic or national origins include being from a Roma background or of Chinese heritage. A racial group could be "black Britons" which would encompass those people who are both black and who are British citizens].
- **religion or belief** [for example the Baha'i faith, Buddhism, Christianity, Hinduism, Islam, Jainism, Judaism, Rastafarianism, Sikhism and Zoroastrianism are all religions for the purposes of this provision. Beliefs such as humanism and atheism would be beliefs for the purposes of this provision but adherence to a particular football team would not be].
- **sex**

- **sexual orientation** [for example a man who experiences sexual attraction towards both men and women is "bisexual" in terms of sexual orientation even if he has only had relationships with women. A man and a woman who are both attracted only to people of the opposite sex from them share a sexual orientation. A man who is attracted only to other men is a gay man. A woman who is attracted only to other women is a lesbian. So, a gay man and a lesbian share a sexual orientation].

10.2 Section 6 of the Act defines 'disability' as:

[1] A person [P] has a disability if—

[a] P has a physical or mental impairment, and

[b] The impairment has a substantial and long-term adverse effect on P's ability to carry out normal day-to-day activities[5].

10.3 Charles and Thomas were born in the United Kingdom and their ethnicity is White British. There is nothing within Charles' family background or medical history to indicate he lacked capacity to understand either the spoken or written word. There was some concern within the family shortly before Charles' manslaughter that he might be displaying the early signs of a condition such as dementia. However, there is nothing in his medical records to substantiate this. In all other respects, Charles appears to have been ambulant and fit and well for a man of his age. Consequently, Charles could not be said to be living with a disability within the meaning of this Act.

10.4 Thomas had a diagnosis of Asperger's Syndrome which was made when he was a child and for which he received specialist services at Alder Hey Children's hospital. While this condition remained with him, he was discharged from specialist services when he reached adulthood and there is no evidence in medical records that he received any further treatment for this condition. When Thomas was examined by a clinical psychologist instructed by his defence they concluded the correct diagnosis for Thomas was that he suffered from Autism Spectrum Disorder[6]. Therefore Thomas has a disability as defined by the Act. Further information about his condition is included later in this report. The review did not find any evidence Thomas was faced with barriers to accessing services because of this. However [see paragraph 12.20] there is some evidence that Thomas' disability impacted upon his employment opportunities.

[5] Addiction/Dependency to alcohol or illegal drugs are excluded from the definition of disability.

[6] The way in which Asperger's Syndrome is classified has changed since Thomas was discharged from specialist services. Asperger's Syndrome is now considered to be a form of Autism.

10.5 Given Charles was 90 at the time of his manslaughter, consideration was given as to whether he might have faced barriers in relation to accessing services. Thomas was much younger at 20 years of age. The panel did not find any examples that indicated either Charles or Thomas was discriminated against because of their age or faced barriers or difficulties to accessing services because of age.

10.6 Charles was a devout Catholic and spoke openly about his faith. Similarly the review looked carefully to see if Charles faced barriers to accessing service or suffered any discrimination because of his faith. The review found no evidence this was the case. However, the review did find evidence that Charles behaviour towards others was sometimes intolerant and appeared to be influenced by his own religious beliefs. These occasions are highlighted within the report.

10.7 The review established that both Charles and Thomas were heterosexual males. The review found no evidence to indicate they suffered discrimination nor barriers to accessing services because of their sex or sexual orientation.

10.8 The review did find that debt, poverty and securing employment were a significant feature of the life of this family. While socioeconomic characteristics are not specific defined within the Equality Act 2010, these factors undoubtedly placed strains on relationships within the family.

11. DISSEMINATION

11.1 The following organisations/people will receive a copy of the report after any amendment following the Home Office's quality assurance process.

- The Family
- Sefton Safer Communities Partnership
- Merseyside Safeguarding Adults Board
- The agencies that contributed to the review
- Police and Crime Commissioner for Merseyside

12. BACKGROUND INFORMATION

12.1 The information in this section was drawn from the meetings the Chair had with Anna and enquiries made by the panel. As well as providing an IMR, Merseyside Police also allowed the DHR access to a number of key witness statements. This proved valuable in helping the panel build up a picture of Charles' and Thomas' lives and their relationship. It is noteworthy that Charles was able to provide the police with a statement before he died in which he outlined what had happened on the day he was assaulted and which ultimately led to his manslaughter. The panel are grateful for the police providing them with a copy of this as, in a small way, it allows Charles' voice to be heard.

Background of Charles

12.2 There was little background information available to the panel with which to build a picture of Charles' life before he met Janette. He had a brother and a sister both of whom predeceased him. There is nothing known about his education. He is believed to have been born in Bootle and to have worked for most of his life in factories in that area. He had no convictions and, other than the events set out within section 13, was not known to Merseyside Police.

12.3 Charles had been married once before. There were no children from the marriage although Charles' first wife did have a son from a previous marriage. The panel have been told that Charles and his stepson had been estranged for a number of years and the panel has not been able to speak to him. Charles' first wife died some years ago.

12.4 Charles was a devout Roman Catholic and worshipped at two churches in the area he lived in. He was an altar server well into his later years and was formerly an active member of the Saint Vincent de Paul Society[7]. When he was in his late 60's Charles met Janette who was then in her mid-thirties.

12.5 Janette had been married before and had one child [Anna]. She was divorced from her first husband when Anna was 3 years of age and they lived together in a flat in the same road as Charles. Janette was a fellow parishioner with Charles and initially the couple were friends, however the relationship developed into an intimate one.

[7] The aim of the charity is to tackle poverty in all its forms through the provision of practical assistance to those in need. https://www.svp.org.uk/what-we-do

12.6 Janette then moved with Anna to address 1. Eventually Charles moved into the address to live with Janette. They married and she gave birth to Thomas who was Charles' only child. There were concerns within Janette's family about the relationship particularly because of the significant age difference between the couple. Janette suffered from mental illness [Bipolar Disorder- a condition Characterised by extreme mood swings]. It was felt that, because of Janette's illness, she was a very vulnerable person. One of Janette's family members described Charles as a bully and said that he was controlling.

12.7 Other family members describe a similar picture. They said that Charles had full control over Janette and that every day was planned around Charles' needs which she had to cater for. This family member said Charles had a temper and if anyone stood up to him he would snap. Charles' religious devotion was also said to be an issue and he regarded anyone that did not attend church as being unimportant.

12.8 Independent witnesses gave a similar description. A lady in the community said that Charles would often come into her shop demanding cigarettes on account for Janette. She said he would shout at her and call her a 'bitch' if she would not give them to him. He also castigated her for being an unmarried mother and would push his fist close to her face. This person also described controlling behaviour by Charles towards Janette. She said when Janette was having a cup of tea with her, Charles would come in and demand Janette returned home.

12.9 In her interview with the police, Janette provided her perspective. She said there had been both good times and bad times. She acknowledged Charles had a quick temper. However, she said he had not hit her nor had he hit Thomas as an adult; although he had as a small child when Janette said Thomas might have bitten his father. Janette said that any arguments between her and Charles were mainly over her smoking. She said that Charles was good hearted and could be generous. She described how he gave her all his pension money and also bought the children items such as football boots for Thomas. However, Janette did acknowledge that her daughter Anna had a different perspective of family life and had told her mother that Charles had always had a temper and that was one of the reasons she left home.

12.10 Janette described Charles as starting to display signs that might be associated with some kind of dementia, not long before he died. She said he became confused over the days of the week and did strange things such as leaving his comb in the fridge. She recognised Charles needed a memory assessment, however she said he would not have consented to participating

in one. There is nothing in his medical records to indicate Janette raised this issue with the GP or that a memory test was ever considered.

12.11 Financial poverty appeared to be a significant aspect of Charles and Janette's life. Charles was said to have called at neighbours' houses on occasions asking for money either saying they had no food in the house or that Janette needed cigarettes. One of these occasions led to the police becoming involved and is documented in more detail later in this report. [see paragraph 13.3.2].

12.12 Anna also provided useful background on the family finances. She said there was debt in the household. Although Charles received a pension, and her mother received some benefits, Charles also had a large overdraft and struggled to run a car. Eventually he gave it up because of the insurance costs related to his age.

12.13 Anna said that when Thomas grew up the child benefits stopped. In the last few years, Janette's personal independent payment [PIP] and employment support allowance [ESA] were cut and she was told to go back to work; something she had not done for years. This increased the financial pressure upon the family.

12.14 The DHR panel made enquiries with the Catholic Arch Diocese Safeguarding Officer to establish if there was any information held within either of the parishes Charles and Janette attended. As a result of this, the Chair and Carol Ellwood-Clarke QPM visited one of the parishes and met with the priest. He had known Charles for about thirty years.

12.15 He described Charles and Janette as regular church goers. He said Charles could be aggressive in his attitude and could easily fall out with someone if there was a disagreement. The priest said that had happened between him and Charles on one occasion, which was what led to him and Janette attending the other parish where they were married. The priest said Charles had asked all sorts of people in the parish for money, including the priest himself. While the story given was that it was for cat food, he strongly suspected it was for cigarettes.

12.16 The parish priest told the DHR Chair that Charles had disclosed to him that he and Thomas squabbled. Charles told the priest that he had tried to get his son to attend mass. However, Charles had not disclosed any information to the priest to indicate that Thomas had assaulted him. The last time the parish priest saw Charles was when he visited him in hospital shortly before he died.

Background of Thomas

12.17 Thomas was born when Charles was 70 years of age and Janette 38 years of age. Anna said her mother and stepfather's marriage was not a normal one and when Thomas was born Janette did not cope well. She said Charles did not know how to be a father because of his age when Thomas was born.

12.18 Anna said Thomas had development needs as a child and was in nappies until school age[8]. She said he was just expected to work out toilet training himself. He had tests for Asperger's Syndrome and as a child had some anger management issues. Anna says, when Thomas was 3 or 4 years of age, he would hurt himself by banging his head constantly on the window ledge.

12.19 Thomas was educated in main stream schools in the Sefton area and left when he was 16 years of age. He did not gain any GCSE's while at school although Anna said that he did try hard to pass his English and Maths GCSE's. Thomas was very keen on football and was successful in gaining some qualifications in that field.

12.20 Because of learning difficulties Thomas struggled to gain and retain employment, mainly holding jobs with zero hours contracts. These were with large brand chains in the food and drink sector. Anna described Thomas as being unable to tell an untruth because of his learning difficulties. This led to him losing one of his jobs. He had taken sick leave and inadvertently told his employer that, while off work, he had been visiting a friend which led to him being dismissed. On another occasion he was made to sign a pre-prepared resignation letter. Anna said her brother's learning difficulties meant he was limited in undertaking some tasks.

12.21 Thomas was very keen on football and was an ardent Liverpool FC fan. He was successful in gaining a position as a steward on match days. He loved to watch football on television when there was no match to see at Anfield. Thomas lived his whole life at address 1 and was still resident there when the homicide of Charles occurred.

12.22 At that time Thomas was in a relationship with a female who lived with her parents in the Liverpool area. They had been seeing each other twice a week for about 12 months. At the time of Charles's homicide, his girlfriend was pregnant and gave birth to their daughter during June 2019.

[8]Anna also said Thomas was actually kept behind in the nursery school instead of moving up to Reception. He then had to skip ahead from Year 5 to secondary school.

12.23 Thomas had no convictions recorded against him before the homicide. Despite that fact, there is some evidence to show that Thomas may have been prone to aggressive or intemperate behaviour. For example, the following historic issues from his childhood; Anna's account that he had anger management issues as a child and the SWACA caseworker who reported Thomas said he sometimes hit his mother when she hit him [see paragraph 13.2.9].

12.24 As well as this historic information about his childhood behaviour, this report contains other information to indicate Thomas behaved in an aggressive way towards his father. For example Janette reported to their GP in March 2019 a fight between Thomas and Charles in which Charles received a black eye. Janette stated this was the third time that Thomas had punched his father [this event is considered in more depth at paragraph 13.3.5].

12.25 Prior to Charles' manslaughter, and in his statement to the police, he described how Thomas came down the stairs and was angry because he and Janette had asked him for money. Following this Thomas punched Charles at least three times to the face/stomach [this event is considered in more depth at paragraph 13.3.21].

12.26 Finally, during the police interview after his father's manslaughter, Thomas admitted hitting Charles on about six or seven occasions since leaving school. He also confirmed that his father had not been violent with him in the past.

Charles and Thomas' Relationship

12.27 Anna has a few happy memories of life with Charles from her early childhood years. She recalled that before he married Janette, he took them to places such as visits to castles in Wales in his car. However, when Charles moved into address 1 and married her mother, Anna described life as terrible. She said his behaviour was a constant feature in her life and he was an aggressive bully.

12.28 Anna recalls Charles shouting at her and said she threw herself into her school work as a coping mechanism. Anna described lots of shouting between her mother and Charles. She said Charles was not physically violent (except on one occasion described later) although she now recognises his conduct amounted to emotional abuse. Anna said, because of her mother's illness, Janette also behaved violently towards Charles.

12.29 Life for Thomas was terrible said Anna. Charles had a short temper and often hit Thomas. She said he was brought up in an environment with violence. Charles would not let Thomas have any toys in the house because he didn't

like clutter and they were all kept in the shed. When she was about 12 or 13 Anna recalls covertly bringing Thomas' toys into the house and warming them by the fire. Because he had no toys Anna believes this led to Thomas having no imagination.

12.30 Anna said she had an awful time as a teenager and hated home life. Her mother and Charles did not spend any money on clothes for her and she had to buy everything herself using birthday money or earnings from part time jobs. She said that when she was a teenager she eventually stood up to Charles, which made him angry and on one occasion he pushed her over onto a settee.

12.31 She left home at the earliest opportunity three weeks after her 18th birthday. Apart from occasional visits to see her mother she never returned to address 1 and during holidays stayed in the city where she was studying at university. Anna said Thomas was about 7 or 8 years of age when she left address 1.

12.32 To cope with his childhood anger management issues, Thomas was given a small yellow soft toy to squeeze when he felt angry. He called this his, "angry man". Anna recalls visiting address 1 when she was at university. Thomas had become angry for some reason, possibly because Charles had shouted at him. Thomas tried to use his 'angry man' toy however Charles snatched it off him, threw it against the wall and it broke. Anna recalled Charles shouting at Thomas "I'll give you an angry man": meaning himself.

12.33 Anna said she had never witnessed nor been aware of Thomas directing violence at Charles. She did hear from her mother about an incident in late 2018 [see paragraph 13.3.6] when Charles and Thomas had argued and this had resulted in a fight. Anna said she was told the argument started because Charles had called Thomas 'stupid' and 'simple'. She said this was the occasion of Charles' birthday and was also told that Thomas had a few drinks.

12.34 After the incident which led to Charles' manslaughter and before he died, Janette told Anna there had been an argument and a fight between Charles and Thomas. Janette told Anna that Charles had asked Thomas for money. However, when Janette told her this Anna said she did not realise how serious Charles' injuries were. Anna said that Charles was a strong and fit man for his age. She said that, in the area she was brought up in around address 1, it was quite common for boys to fight with their fathers.

12.35 Members of the community also provided testimony about the relationship between Thomas and Charles and said they were not surprised by the events that unfolded. They described Charles often shouting at his son. One person

heard Charles once threaten Thomas and say, 'I will put my fist in your face'. About 2 years before the homicide, a member of the community recalled Thomas walking away from address 1 followed by Charles. He was swearing at his son telling him to get home, and that he wanted the money. Thomas was quiet and did not answer back. Charles slapped his son on the side of the head. Thomas said nothing and walked off. This person knew the family well and said they felt Charles could be very controlling and aggressive.

12.36 When she was interviewed by the police, Janette was asked about Charles and Thomas' relationship. She said it was "On and off". Although she accepted it was rocky, she also said there had been good times between them. For example, Charles put goal posts up in the garden to play football and Thomas had been given many football tops. Even though they supported different Liverpool football teams, Janette said Thomas would volunteer to change the television channels for Charles and they would sit and watch football together. She said Charles did worry about Thomas, for example checking to see if he was home at night from football training. Janette said she and Thomas had a better relationship as mother and son. For example he would talk to her about his search for jobs and take an interest in what she had done that day.

12.37 After Charles' homicide Janette provided a victim impact statement. She said that life had been hard since the homicide. It had been stressful for her going to the hospital and distressing dealing with the funeral arrangements. Because the couple had got into debt Charles' life insurance was not sufficient for a burial and instead this had been paid through a funeral expense's payment[9].

12.38 Janette said Thomas had been deeply affected by his father's manslaughter and sobbed his heart out at the funeral. She said he was a good son. She missed him a lot and was very worried about him when he was arrested by the police. It was her hope that he did not go to prison. Janette said she did not blame Thomas for Charles' manslaughter. She said she had already lost her husband and did not want to lose her son as well.

12.39 The panel recognise that Anna has provided an extensive account about her knowledge of Charles and it includes allegations of domestic abuse by him. The panel feel it is important to ensure readers recognise that account is not supported by Janette who, when interviewed by the police, did not provide

[9] Under certain circumstances surviving spouses and partners who are eligible for state benefits may also be eligible for financial support with funeral costs. https://www.gov.uk/funeral-payments

testimony as to domestic abuse by Charles. Neither when interviewed by the police, shortly before he died, did Charles make any admissions that he had behaved in such a way. Because he died before these allegations were reported by Anna, the police did not have an opportunity to ask Charles about them. The panel feel it is important to balance that information when considering what Anna says about Charles and to recognise that, irrespective of what allegations may have been made about him, he remains the victim of a domestic homicide and the focus of this review.

13. CHRONOLOGY OF EVENTS AND FACTS

13.1 Introduction

13.1 This section of the report sets out a detailed chronology of the events that took place leading up to the homicide of Charles. Rather than presenting information individually by agency, a chronological approach has been adopted to aid the reading and understanding of these events. This section contains the information that was known to agencies and supplied to the DHR in their IMRs, chronologies and reports as well as information gathered by Merseyside Police during their homicide enquiry.

13.2 Events pre-dating the terms of reference

13.2.1 The earliest historic record held by any agency is from July 1998 when a health professional requested Sefton Children's Social Care undertake an assessment of need[10]. There is nothing further within the records to indicate why that request was made or what the outcome was. Given the request was a few days after Thomas' date of birth it may be a midwife or community nurse had identified some concerns about him or the family circumstances.

13.2.2 In May 2003 a health visitor reported to Sefton Children's Social Care that Janette had mental health difficulties and that Thomas had developmental delay and was a loner. Janette was said to have declined the support of a parenting group and there were concerns about neglect. The following month a family support worker visited and undertook an initial assessment of need. The recommendation from the assessment was that no further action was required.

13.2.3 On 6 August 2003 a mental health nurse contacted Sefton Children's Social Care and requested an assessment of Thomas. The mental health team had been contacted by Merseyside Police following a domestic abuse incident involving Charles and Janette. Thomas was seen by a police officer to be hiding in a cupboard and wearing a nappy. When the mental health nurse visited, Thomas appeared agitated. Charles and Thomas had left address 1 and were reported to be staying with an aunt while Janette had been taken to see a psychiatrist by the mental health nurse.

[10] Under Section 17 Children Act 1989, a child will be considered in need if; they are unlikely to achieve or maintain or to have the opportunity to achieve or maintain a reasonable standard of health or development without provision of services from the Local Authority; their health or development is likely to be significantly impaired, or further impaired, without the provision of services from the Local Authority; they have a disability.

13.2.4 Two days after this request a family support worker visited the family and undertook an initial assessment. The recommendation from the assessment was that no further action was needed.

13.2.5 There are two domestic incidents in 2004 and 2005 recorded by Merseyside Police relating to Charles. On both of these occasions he was recorded as a victim when Janette behaved aggressively towards him. Her behaviour was due to her poor mental health. She was removed to hospital and no further police action was taken. The family told the DHR that around this time they recall Janette being compulsorily detained in hospital under the Mental Health Act [so called sectioning][11].

13.2.6 Information provided by a nurse and recorded in Sefton Children's Social Care on 23 May 2004 states Charles had been assaulted by Janette and that Thomas was now in the care of his father. Janette had been admitted to a local hospital that provided assessment and immediate care for persons who need mental health services. This correlates with the family's recollection that Janette was compulsorily detained. On 28 May 2004 a social worker undertook an assessment of need for Thomas and no further action was recommended.

13.2.7 On 21 December 2004 Sefton Children's Social Care were contacted by a community psychiatric nurse who reported Thomas was witnessing domestic abuse between his parents and that Janette was assaulting Charles. Thomas tried to prevent this and was emotionally withdrawn with nocturnal enuresis[12]. An initial assessment was undertaken which in turn led to an investigation under S47 of the Children's Act 1989[13].

13.2.8 The outcome of this enquiry was that an initial child protection conference was convened and Thomas was made the subject of a child protection plan. A child protection plan is a plan drawn up by the local authority that sets out how a child can be kept safe, how things can be made better for the family

[11] Being sectioned means being admitted to hospital whether or not a person agrees to it. The legal authority for admission to hospital comes from the Mental Health Act 1983 rather than from a person's consent. This is usually because the person is unable or unwilling to consent.

[12] The involuntary discharge of urine during sleep, which is common in young children. Children are generally expected to be dry by a developmental age of 5 years, and historically it has been common practice to consider children for treatment only when they reach 7 years; however, symptoms may still persist in a small proportion by the age of 10 years [Source: National Institute for Care and Health Excellence [NICE]]

[13] Children's Social Care must carry out an investigation when they have 'reasonable cause to suspect that a child who lives, or is found, in their area is suffering, or is likely to suffer, significant harm'. The aim is to decide whether any action should be taken to safeguard the child.

and what support they will need. Parents should be told: the reason for the plan and what they should do to make sure the child is protected[14].

13.2.9 Sefton Women's and Children's Aid [SWACA][15] told the panel they were contacted by a social worker who requested SWACA engage with Thomas. A SWACA Caseworker was allocated and visited him at home and at his school. This also involved various contacts with the Headteacher. In March 2005, on a first home visit, the SWACA Caseworker reported Janette said she was unhappy with Thomas' behaviour. There was felt to be a volatile relationship between Thomas and his Mum. In turn, Thomas spoke about his Mum shouting at his father. Thomas said Janette had sometimes hit him on the chest and thigh. Thomas said he sometimes hit his Mum when she hit him. The caseworker recorded that Thomas often had to be asked questions several times before he understood and responded.

13.2.10 SWACA continued to engage with the family and there are references to their attendance at a child protection review meeting in May 2005. By October 2005, their records show Janette was receiving new medication and issues at home had significantly improved. On 4 October 2005 a child protection review meeting was held. The outcome of this was that the child protection plan for Thomas ended. Instead support continued through a family support agreement. SWACA records show that in November and December 2005 there was no evidence of any violence at home. Consequently, in March 2006 SWACA closed the case. The family support agreement ended on 14 November 2006 at which time the case was also closed to Sefton Children's Social Care.

13.2.11 Janette and Charles registered as tenants of address 1 with One Vision Housing [henceforth known as OVH-a social housing provider] on 30 October 2006. OVH have checked their records and have no information of any relevance to this DHR relating to this address [with the one exception outlined at paragraph 13.3.5].

13.2.12 As a child and young person Thomas received support from the Learning Disabilities Team. He was also under the care of a specialist at Alder Hey Children's NHS Foundation Trust community paediatric clinic for Asperger's Syndrome. Thomas was discharged from that service on 6 November 2014 when $16^{1/2}$ years of age. A letter from the hospital to the GP surgery stated he was doing well and that his parents had no particular concerns about him

[14] Source: Citizens Advice-Child Protection Plans www.citizensadvice.org.uk

[15] SWACA's dedicated team help women, young people and children survive the impact of Domestic Abuse by giving free practical and emotional support. Their services are offered regardless of Age, Disability, Sexuality, Race or Religion. Support can be given by phone, in person, in school, in the workplace, in Children's Centres or in our Centre. www.swaca.com

at home. There is no indication that Thomas received any further specialist support from social care, education or health agencies after the age of 16 1/2 years and his only engagement beyond this point was with his GP surgery.

13.3 Events during the period of the terms of reference

13.3.1 Thomas' GP surgery told the DHR they reviewed his medical records in line with the terms of reference. They told the review there was no information that was relevant to the terms of reference for the DHR. Charles registered with his GP in April 2017. This was the same GP surgery as his son Thomas. Charles had regular telephone and face to face consultations with the surgery for routine medical matters. With the exception of the consultations on 25 March 2019, there was nothing that was of any relevance to this DHR.

13.3.2 On 8 August 2018 at 16.04hrs the police received an emergency call from a woman who said Charles had just threatened her with a knife. She had called at address 1 to speak to him about borrowing money from her elderly mother earlier that day. Police officers attended immediately and ensured all parties were safe and well. The woman who made the call did not want a prosecution. Officers spoke to Charles, who denied behaving in the way the woman described. He showed police officers a letter opener which he just happened to have in his hand when he answered the front door. There were no referrals to any agencies and no follow up, save for that below.

13.3.3 During the homicide enquiry the police revisited this event and recorded a statement from the woman who reported this incident. She said the event on 8 August started after Janette had asked her mother for £10-£20 for cigarettes. This elderly woman had dementia and her daughter objected to Janette's actions. When the daughter visited address 1 and remonstrated with Janette, she said she was going to repay the mother.

13.3.4 At that point Charles came out saying how dare she ask for the money back. He started swearing at the woman calling her names. He then pulled a knife out of his pocket waving it in the woman's face. He did not give the woman the money back that day. She described him as having a bad attitude and being a horrible man. The woman was content with the actions of the police. She said she wanted them to speak to Charles and did not want them to take any further action.

13.3.5 On 9 August 2018 OVH received a report that Janette and Charles were screaming and shouting at each other. The informant stated they were fighting in the garden. OVH sent a neighbourhood officer to address 1 and they spoke to Janette. She explained that she and Charles had an argument over money and that it would not happen again. Janette was spoken to in relation to the tenancy and no further action was taken by OVH.

13.3.6 On 18 August 2018 at 23.04hrs the police received an emergency call from an anonymous person. They said they had heard loud banging and a male voice shouting, emanating from address 1 for the last hour. A police officer attended address 1 and found a domestic incident had occurred during a birthday party for Charles. Thomas had reacted adversely to a conversation about people working. He was sensitive about being unemployed at the time. The officer confirmed that everyone was safe and well and no offences were disclosed. They completed a VPRF 1[16] and the incident was graded as bronze[17] and a letter sent to Charles who was recorded as the victim. The letter sent by Merseyside Police provided Charles with contact details for both Merseyside Police and alternatively support agencies.

13.3.7 About 11.00hrs on 28 September 2018 Charles attended a walk-in centre provided by North West Boroughs Healthcare NHS Foundation Trust [henceforth known as NWB] for treatment to an injury. He had a cut to his arm which he said had been caused on a coffee table. He was noted to have bruising to his forearm [he was said to be prone to bruising due to the use of steroid inhalers]. Staff treated the wound and applied a dressing. Charles was discharged from the centre and advised he could be seen again if there were any other problems. He was seen again on 4 October 2018 for the wound to be dressed.

13.3.8 At 08.04hrs on 26 October 2018 Charles and Janette visited the NWB walk-in centre again. On this occasion Charles said he had been assaulted by his son who had been drinking and was angry, due to conditions at home. A query on the notes suggested his son might have mental health problems and had recently lost his job.

13.3.9 Charles was examined and found to have a laceration to the left side of his head about 1.5cm in length. This was glued and advice was given on aftercare. Staff from the walk-in centre gained Charles' consent and submitted a safeguarding adult alert to Sefton Council. The same day Sefton Council Adult Social Care Dept [ASC] contacted the walk-in centre acknowledged the referral and said they would speak to Charles.

13.3.10 Sefton ASC received the referral from the walk-in centre within three hours of Charles and Janette's visit. Medical staff said the couple told them Thomas had returned from the pub drunk, to discover the Virgin media service cut off. He then assaulted Charles by punching him in the arm and head. Janette had told staff she was bi-polar and Thomas often went to the pub and had recently lost his job. Either Charles or Janette then told staff Thomas had

[16] A Vulnerable Person Referral Form [VFPR] is a form completed by Merseyside Police Officers whenever they attend a domestic dispute or have concerns about someone.
[17]Merseyside Police grade domestic incidents according to their nature and the type of follow up response required using bronze, silver and gold.

assaulted his father before. It is not clear from the disclosure which one of them provided that information.

13.3.11 A Triage worker from ASC then telephoned address 1 intending to speak to Charles. Instead it was Janette who answered. She said the internet was now back on so things had calmed down. She said she and Charles had told Thomas that if he "kicks off" again; they would ask him to leave. She said they were now OK. A Decision was made to close the case at triage level as not requiring any further action. ASC received no further referrals until they were notified by Aintree Hospital of the incident resulting in Charles being hospitalised on 27 March 2019.

13.3.12 On 30 October 2018 Charles and his wife visited the NWB walk-in centre for the wound to be re-dressed. Janette told staff someone from the council had been in touch about the referral and had given them advice. She said they had not had contact with their son since. Charles returned on 2 and 8 November 2018 to have the wound redressed on which latter date he was discharged from the walk-in centre.

13.3.13 NWB notified Charles' GP surgery about the visit to the walk-in centre on 26 October. The notification received by the surgery stated Charles had been allegedly assaulted by Thomas the previous day [25th October 2018]. The report detailed that Thomas had been drinking alcohol, had recently lost his job and there was a query as to whether Thomas had a mental health issue.

13.3.14 Charles did not attend the GP surgery for any care or treatment in relation to this incident. The notification from NWB was coded on the GP system as 'assault' and the narrative stated the walk-in centre made a referral to adult safeguarding. The notification stated the police had been called previously although not on this occasion.

13.3.15 About 13.00hrs on 25th March 2019, a GP at the surgery where Charles was registered took a telephone consultation from him and Janette. They discussed a 'fight' that had taken place with their son Thomas the previous day. This resulted in Charles sustaining a black eye and nose bleed after having been punched by Thomas in a fight over £10. Janette said this was the 3rd time Thomas had punched his father. The last time it happened she said the police were called although not on this most recent occasion. The GP coded the call on EMIS[18] as a 'safeguarding issue'.

13.3.16 About 15.00hrs the GP made a home visit to address 1. The GP examined Charles. It was reported that Thomas repeatedly punched his father to the

[18] EMIS Health, formerly known as Egton Medical Information Systems, supplies electronic patient record systems and software used in primary care, acute care and community pharmacy in the United Kingdom.

left eye and chest. The GP noted Thomas suffered from Asperger's Syndrome and was due to become a father to his pregnant girlfriend. The examination disclosed no sign of a fracture to the orbital bones [these are bones in the face around the eye] and there was no bruising to the chest wall at that time. The GP recalled Thomas was in the house upstairs when they attended for the home visit.

13.3.17 The GP advised Charles to take codeine phosphate for pain relief. They discussed making an adult safeguarding referral to social care. Both Charles and his wife consented to this. The referral to adult safeguarding was completed at the surgery the following day [26 March 2019]. There were no further contacts between Charles and the GP surgery.

13.3.18 At 19.02hrs on 27 March 2019 the police responded to a priority call from a member of the community who had visited address 1. This person had seen Charles was injured and was struggling to breathe. Charles told them he was attacked on 24 March by Thomas. Janette had prevented this person calling an ambulance as she did not want Thomas to be arrested.

13.3.19 Police officers attending address 1, summoned an ambulance and Charles was taken to hospital at Aintree where he was admitted for treatment. The hospital submitted a safeguarding referral to City of Liverpool Council Adult Services at 23.27hrs that day. The referral included information that Charles had been assaulted by his son and this was a regular occurrence.

13.3.20 Police officers arrested Thomas, who was present at address 1, on suspicion of assaulting Charles. They commenced an investigation and spoke to the member of the public who had contacted them. That person did not wish to provide a statement to the police. However, they did tell the police they were aware of previous domestic incidents at address 1 although they had not reported them.

13.3.21 Police officers were able to speak to Charles in hospital and gain an account of what had happened. He said he could remember being at the front door and was going to the shop to buy cigarettes for Janette. He said Thomas came down the stairs and was angry because he and Janette had asked him for £10.00. Charles said Thomas punched him at least three times to his face and also once to his left side near his stomach.

13.3.22 Charles said the force of the blows was such that he nearly fell down the step. His nose was bleeding a lot. Janette came to help him while Thomas went back up the stairs. Charles said Thomas had been angry with him before and had hit him three times previously. He said Thomas had also punched the living room door before. Charles said he did not know why Thomas got angry and that he had Asperger's Syndrome.

13.3.23 Janette provided the police with a similar account saying the event happened after she and Charles came home from church. Janette said she had asked Thomas to lend her £10 for cigarettes, cat food and milk. While Janette was in the kitchen she heard an argument develop and Charles shouted at Thomas.

13.3.24 Janette saw punches exchanged and separated the pair. Charles' nose was bleeding and she took him into the lounge. Thomas had a cut lip. At first Thomas said he was sorry to his father, then he went and hid upstairs. Janette described the event happening in seconds 'like a firework'. She said Thomas had been provoked by his father. In the days that followed Janette said Thomas tended to his father making him cups of tea and putting him on the couch. She was shocked when Charles died in hospital a few weeks later.

13.3.25 A post mortem established Charles had facial injuries including fractures of the cheek bone, upper jaw and ribs. These injuries were due to the assault on 24 March 2019. When admitted to hospital on 27 March he had signs of pneumonia. The cause of his manslaughter was:-

1a Bronchopneumonia.

b Blunt chest trauma and facial trauma.

death was due to the consequences of the assault.

13.3.26 Prior to sentencing at the Crown Court Thomas was examined by a clinical psychologist appointed by his defence. They diagnosed Thomas suffered from autism spectrum disorder rather than Asperger's Syndrome. The media reported the sentencing judge told Thomas that, despite being on the autism spectrum, he must have appreciated he should not have repeatedly punched his elderly dad in the face and had intended or been reckless whether harm was caused and consequently only an immediate prison sentence was justified[19].

13.3.27 The panel feel it is important to recognise that the sentencing judge's comments do not allude to Charles' behaviour contributing to his homicide.

[19] https://planetradio.co.uk/city/local/news/

14. ANALYSIS USING THE TERMS OF REFERENCE

Introduction

This section of the report looks at each of the terms requiring analysis as listed in Section 3. The individual terms appear below in bold followed by the analysis. Some of the material and events that are analysed may be relevant to more than one term and where this occurs a best fit approach has been adopted to avoid unnecessary repetition.

14.1 Term 1.

What indicators of domestic abuse, including coercive and controlling behaviour, did your agency have that could have identified Charles as a victim of domestic abuse and what was your response.

14.1.1 The first indicators that agencies could have recognised Charles was a victim of domestic abuse were the two historic events in 2004 and 2005. Given these events happened over 15 years ago, and were the result of Janette's mental health crisis, the DHR panel concluded they did not require further analysis. The panel felt there was no direct connection between these events and the risk Charles faced from Thomas in 2018. However, they did recognise these events may have been indicative of a chaotic environment that Thomas was raised in and they have made further commentary about this later in the report.

14.1.2 The next occasion when a potential indicator may have been identified was when OVH received a call concerning Charles and Janette screaming and fighting in the garden [see paragraph 13.3.5]. There is no information to suggest Thomas was involved in this event. It does not appear this matter was identified as a potential domestic incident and there is no indication as to who was the perpetrator or who was the victim. The panel asked OVH to provide further information on the way this incident was dealt with, and whether it complied with OVH's domestic abuse policy. The Independent Living Manager from OVH spoke to the Neighbourhood Housing Officer who responded to this event and they provided the following information.

14.1.3 They confirmed OVH does have a policy that addresses the areas of Anti-Social Behaviour, Domestic Abuse and Harassment. Any domestic abuse or wider safeguarding concerns are logged on OVH's internal safeguarding reporting system. They also use the same risk assessment process used for

MARAC referrals. OVH have also signed up to the 'Making a Stand' initiative[20]. The housing officer said they had attended address 1 several times previously regarding rent. They had no concerns, nor had they received any previous reports there were issues around domestic abuse in the household.

14.1.4 They had met Charles and Janette before and were aware of Janette's mental health needs and Thomas' learning disabilities. The housing officer said Charles and Janette both seemed to be worried about their rent, although there was nothing to suggest there were any other household issues.

14.1.5 The housing officer therefore treated this as an isolated incident. They did not consider this to be a domestic abuse incident and consequently it was not recorded as such within the domestic abuse policy of OVH. The housing officer was asked by their manager what they would have done if they had concerns about potential domestic abuse. The housing officer said they would have discussed it with their manager as it would be a major safeguarding concern. The housing officer said they would have done this immediately if they had any concerns for the safety of any member of the household. They said they would have sought a second opinion on the steps they would need to take and would also have asked the Anti-Social Behaviour team to support and advise them in relation to the involvement of the police and any other appropriate actions as needed.

14.1.6 The DHR panel considered the actions taken by OVH. They recognised that deciding whether to record and then initiate domestic policies is a matter of judgment based on immediately available and historic information about risk supported by experience and training. On this occasion the DHR panel felt the housing officer had used all of the information they had available, their previous knowledge of the family and had made an appropriate decision not to treat this incident as one of domestic abuse. It is clear from what they told their manager that, if they had concerns that one of the family members was at risk, they knew what to do and how to escalate concerns.

14.1.7 The next occasion that Charles was identified as a victim of domestic abuse was on 8 August 2018 when the police attended to the report of banging and shouting [see paragraph 13.3.6]. The officer involved correctly identified this as a domestic incident and completed the appropriate report. There was no indication that Charles sustained any injuries as a result of this incident.

[20] Make a Stand was launched in June 2018 as part of the Chartered Institute of Housing [then] President's appeal to tackle domestic abuse. It centres around a pledge developed in partnership with the Domestic abuse Housing Alliance (DAHA) and Women's Aid to tackle domestic abuse. The Chartered Institute of Housing is the independent voice for housing and the home of professional standards: http://www.cih.org

The DHR panel feel the actions of the police were appropriate in response to this single incident.

14.1.8 The event on 28 September 2018, when Charles attended the walk-in centre [see paragraph 13.3.7] was not recorded as a domestic incident. The explanation given to staff was that Charles had fallen against a coffee table. Given his age, his proclivity for bruising and in the absence of other information, that would appear to be a reasonable explanation. Based on this single presentation the DHR panel felt the actions of staff were reasonable and there was no reason why this information needed to be shared. However, based upon what the panel now know, it is probable this injury was not accidental and may well have been sustained during a domestic incident.

14.1.9 The event of 26 October 2018 was a clear indicator of domestic abuse and Charles told staff at the Walk-in centre that his son was responsible [see paragraph 13.3.8]. The DHR panel recognised the response of staff, by immediately submitting an adult safeguarding referral, was the correct decision. However, the panel also felt there were other courses of action that could have been explored. All NHS Trusts have a responsibility to have domestic abuse policies in place that include training staff about recognising indicators.

14.1.10 On this occasion the panel felt the walk-in centre could have identified this as domestic abuse and completed a risk assessment and followed their agency's domestic abuse policy. The DHR panel feel the heart of the issue, and the reason this did not happen, is that staff did not recognise this was both a safeguarding adults' case as well as one of domestic abuse. The panel feel this is a key piece of learning and a message that needs to be reinforced to staff [see lesson 3 and recommendations 1,2,4 & 5].

14.1.11 The DHR panel make these comments in light of other DHR's in Sefton with the theme of familial domestic abuse and violence [see section 14.13 for further discussion of this issue]. Panel members are also aware there have been several Safeguarding Adult Reviews [SAR][21] across the wider Merseyside area in which agencies made referrals to adult social care without taking any other action when they could have referred the individual to other support services or processes. The expectation in some cases appears to be

[21] The Care Act 2014 states that Safeguarding Adult Boards (SABs) must arrange a Safeguarding Adult Review (SAR) when an adult in its area dies as a result of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked together more effectively to protect the adult. This is a statutory responsibility.

that, once a referral to adult social care has been made, the referring agencies responsibility ends. The Chair and Carol Elwood-Clarke QPM have worked in other local authority areas completing both DHRs and SARs and concur this is not just an issue for Merseyside and is something they have seen in other reviews.

14.1.12 The DHR panel did not see any further opportunities for agencies to identify Charles as a victim of domestic abuse until he and Janette contacted the GP surgery on 25 March 2019 reporting a fight between him and Thomas [see paragraph 13.3.14]. The response of agencies to this incident is considered in detail within term 2 below.

14.1.13 The DHR panel fully acknowledge that Charles was the victim in this homicide and that responsibility for his manslaughter rests with Thomas as a direct result of the assault he carried out upon his father. However, the DHR panel feel it is also relevant to consider Charles' behaviour which undoubtedly contributed to the chaotic environment in address one.

14.1.14 There is evidence that Charles was abusive to members of the community. For example, his behaviour towards a lady who he called a 'bitch' and castigated for being a single mother [see paragraph 12.8]. Another example is the occasion he was alleged to have confronted a neighbour with a knife over the loan of money [see paragraph 13.3.2]. Although he was described by his parish priest as devout, there was also another side to Charles' behaviour as a parishioner. The parish priest recognised that he could be aggressive and easily fall out with people [see paragraph 12.15].

14.1.15 From the statements the police obtained during the homicide investigation, and from the enquiries made by this DHR panel, it appears Charles' behaviour within the context of family life was abusive to both Janette and Thomas. He was also physically aggressive to Thomas. Family members, including Anna and members of the community provide a good deal of testimony on this issue.

14.1.16 For example, a close member of the family described Charles as a bully and controlling. He was described as having full control of Janette and having a temper that could 'snap' [see paragraph 12.7]. Janette told the police that, while he did have a quick temper, Charles had never hit her. However she did acknowledge that arguments between them happened mainly over cigarettes.

14.1.17 It is clear from the evidence of Anna that Thomas had an extremely difficult upbringing. As well as his mother's mental illness, which made family life

difficult, Thomas was exposed to abusive behaviour from Charles. Anna describes Charles hitting Thomas and, as a child, denying him access to toys. He was also exposed to threats from his father, for example the incident in paragraph 12.21 involving the angry man toy.

14.1.18 The testimony of Anna is also supported by the recollections of community members who describe Charles shouting at Thomas in the street and on one occasion threatening to put his fist in Thomas' face. Another witness described Charles slapping his son in the face while in the street [see paragraph 12.25]. Appendix A sets out the definition of domestic abuse and Appendix B sets out the definition of controlling or coercive behaviour in family relationships.

14.1.19 It is clear to the DHR panel that Charles' actions towards Thomas over a period of many years constitutes behaviour that is controlling and coercive. Many of the examples provided within the definition can be seen in what Charles did to Thomas. He deprived him of toys; he threatened him as a child[22]; he put him down; he enforced rules and exercised control over him. This behaviour was repeated and continuous and clearly had a serious and substantial effect upon Thomas. [This will be discussed later in the report in relation to his diagnosis of autism].

14.1.20 With the benefit of the detailed homicide investigation and the testimony of witnesses, it is now beyond dispute that Charles was a perpetrator of domestic abuse by virtue of his behaviour towards Thomas. While there were concerns amongst the community and within the family, it does not appear that Charles' behaviour ever caused any agency concerns. He had no convictions and was only known to the police as a victim of domestic abuse [see paragraph 13.2.1] until he made a threat to a neighbour in August 2018.

14.1.21 Prior to that event, agency contact with the family appears to have been in relation to Janette's mental wellbeing[23] and Thomas' [then] diagnosis of Asperger's syndrome. Nothing within those contacts, which happened nearly 15 years before this DHR, appear to have thrown up concerns about Charles'

[22] Some of the behaviour of Charles towards Thomas would not have fallen strictly within the definition of domestic abuse [see appendix A] as Thomas as some of it occurred before Thomas reached the age of 16 years. None the less it may well still have constituted behaviour that amounted to an offence of Child cruelty, neglect and violence within Section 1(1) Children and Young Persons Act 1933 as amended by Part 5 Section 66 of the Serious Crime Act 2015

[23] Janette is not the subject of this DHR. The panel has therefore not undertaken a detailed analysis of her contact with health agencies.

behaviour. When Thomas was discharged from Alder Hey Hospital paediatric clinic [see paragraph 13.2.3] the tone of the letter from the clinic to the GP indicates there was no concern about his behaviour at home.

14.1.22 Anna told the DHR Chair when they met that there was an occasion about 15 or 20 years ago when Charles had shouted at her and made her cry. Anna said she told a teacher at her school who sat down and talked to her about it. As far as can be ascertained that incident did not result in a safeguarding referral.

14.2 Term 2.

What risk assessments did your agency undertake for Charles or Thomas; what was the outcome and if you provided services were they fit for purpose? Did Charles have any known vulnerabilities and was he in receipt of any services or support for these?

14.2.1 Prior to the incident in which Charles received the injuries that would eventually prove fatal, there was only one other incident which resulted in the completion of a risk assessment. That was the event of 18 August 2018 [see paragraph 13.3.6].

14.2.2 The attending officer documented within the VPRF that they had signposted Charles to Merseyside Police website to access victim services. Charles was also sent a generic letter from the Multi-Agency Safeguarding Hub [MASH][24] which provided details of support agencies. The IMR author for Merseyside Police states the nature of the incident suggested Charles and Janette may need support to manage their son's Asperger's Syndrome. However, a referral was not made to mental health services. Merseyside Police told the panel the fact a person may have Asperger's Syndrome does not, on its own, constitute grounds for a referral. There would need to be something else that raises the level of need in order to make a referral.

14.2.3 The panel felt the actions of the police in submitting a VFPR and grading the incident as bronze was appropriate given the circumstances and the fact this was the first occasion the police had attended an incident involving Charles and Thomas. Given his age, they felt providing Charles with a letter outlining support services was probably of more value than signposting him to a web site.

14.2.4 The panel felt there were other opportunities to submit risk assessments. For example, the report to OVH concerned an incident of screaming and shouting between Janette and Charles. The panel felt the response of One Vision, sending an officer to speak face to face with Janette, was appropriate.

[24] A Multi-Agency Safeguarding Hub (MASH) allows the police, Local Authorities and other agencies to co-locate safeguarding agencies and their data into a secure, research and decision making unit.

They have already commented upon the appropriateness of the decision made by the housing officer on this occasion not to record the matter as domestic abuse and therefore not to submit a risk assessment. [see paragraph 14.1.6]

14.2.5 When Charles attended the walk-in centre on 28 September [see paragraph 13.3.7] the panel felt the explanation for his injury was reasonable. It did not appear to the panel that the circumstances, as described by Charles and Janette, would have caused staff to consider this was a potential indicator of domestic abuse. Consequently it was reasonable that a risk assessment was not submitted.

14.2.6 The attendance at the walk-in centre on 26 October was different. There was clear evidence from the testimony of Charles and Janette that he had sustained injuries at the hands of his son. While the panel felt it was the correct decision to submit a safeguarding adult referral, they feel there was a missed opportunity here by the walk-in centre to complete a risk assessment and have commented about this earlier at paragraph 14.1.10.

14.2.7 When preparing their IMR, the ASC author questioned the robustness of the decision to close the safeguarding case at this stage, given the advanced age of the victim, his spouse who suffered from mental ill health and their description of a son who had a learning disability. In answer to the question within the safeguarding document 'are safeguarding adult concerns indicated' the option 'no' has been selected by the call handler. The professional opinion of the IMR is this was an error.

14.2.8 The call handler did not speak to the victim directly but rather to his wife. The IMR author states that, while the call handler was not a qualified social worker they had been appropriately trained to screen cases such as this. The IMR author believes the call handler may have been influenced by the person answering the call [Janette] and had no indication that there may have been a problem in terms of the couple's understanding of the risks and deciding not to accept support at that stage.

14.2.9 Had the call taker referred the matter onto the Safeguarding Adults Team the IMR author believes this would have resulted in a safeguarding enquiry under S42 of the Care Act 2014, referral to the police and a possible strategy meeting. At the time of these events the safeguarding process within Sefton was that safeguarding/domestic abuse contacts were screened by triage staff. This has now changed and all safeguarding concerns are screened by safeguarding adult workers and signed off within ASC by managers if they are to be closed or if they are to progress to section 42 enquiry. A revised safeguarding business model has already been agreed and is in a phased stage of implementation.

14.2.10 The DHR panel concur with the views of the ASC IMR author. The panel believe the response of ASC demonstrated a lack of recognition of domestic

abuse as well as the continuing risk to Charles from Thomas. Charles was the victim of a serious crime. There appears to have been no exploration with him personally as to whether the matter should have been reported to the police. Janette also disclosed Thomas was drinking, there was no exploration of this issue and whether support was needed. The disconnection of the internet indicated debt may have been an issue and there appeared to be no exploration of that issue either. Both of the last two issues can be factors that may impact upon the risk of domestic abuse occurring.

14.2.11 While the panel recognise Janette said she was 'OK', and did not require any further support, they feel this case should have gone beyond initial triage. More enquiries should have been made to determine whether Charles was at continuing risk of abuse or neglect. The fact Thomas was still present in the house meant there was still a continuing risk to Charles. While Janette indicated she and Charles might have to ask Thomas to leave, there appeared to be no consideration as to how two elderly and vulnerable parents might achieve that outcome and what might happen if they could not. The panel feel there is an important lessons here for future practice and have made a corresponding recommendation [see lessons 2, 3, & 5].

14.2.12 The telephone call made to the GP by Janette and Charles on 25 March [see paragraph 13.3.14] contained significant information that again identified Charles was at risk from Thomas. The GP surgery already had information from the walk-in centre about the previous assault by Thomas upon Charles. The panel noted that, while the coding correctly identified Charles as the victim of an assault by his son, there was no apparent reference within the letter from the walk-in centre, nor in the coding applied by the GP surgery, that this was also an incident of domestic abuse.

14.2.13 The panel felt the actions of the GP, of arranging to make a home visit that day, was appropriate and indicated the GP recognised they were dealing with an adult with safeguarding needs. When the GP visited address 1, they were aware the assailant [Thomas] was upstairs in the house. They were also told by Charles and Janette that the incident the previous day was not the first, and there had been previous referrals to adult social care and the police in relation to domestic abuse and violence.

14.2.14 While a safeguarding adult referral was made by the GP surgery the following day, the DHR panel felt more immediate action should have been taken that day by the GP. Charles was a man of 90 years of age who had sustained injuries at the hands of his son. Charles and Janette told the GP this was not the first time this had happened. There was also a referral from the walk-in centre about a previous assault that contained information about Thomas' mental health.

14.2.15 GP explained to the IMR author for the surgery that Charles and Janette were calm and willing to discuss the circumstances with Thomas present in the house. The GP say they did not sense any fear from either of them, and

did not believe there was any immediate risk. However, the GP did not explicitly enquire whether the couple felt at immediate risk of harm.

14.2.16 The panel felt that, by not taking more immediate action, such as calling the police, the GP left Charles [and possibly Janette] at further risk from Thomas by virtue of the fact he remained in the house. The GP themselves was also potentially at risk. They had not seen or spoken to Thomas and therefore it was not possible to objectively consider the level of fear Charles and his wife felt. The GP did not complete a risk assessment and had no means of quantifying the level of threat Thomas posed to anyone in address 1. The fact he had carried out at least two assaults upon his father, which had resulted in physical injuries requiring treatment, and that he was still in the house should have been cause for significant concern and immediate action. The panel feel this is an important learning point [see lesson 5 and recommendations 2 & 6].

14.2.17 Although the GP surgery made a safeguarding adult referral the following day, there is no reference within this or within the notes of the GP that identify this incident was also one of domestic abuse. The GP attributed the incident as a safeguarding adult abuse under the category of physical abuse, as opposed to domestic abuse/violence. The IMR author says this was acknowledged by the GP as part of reflective practice who deemed this as an incident of 'elder abuse'.

14.2.18 When the police attended the following day, as well as summoning an ambulance to convey Charles to hospital and arresting Thomas, they also completed a risk assessment and VPRF. The incident was initially assessed as Silver and upgraded to Gold on professional judgement within the MASH. As such the criteria was met for referral to MARAC and IDVA. A Location Information Marker (LOI) was placed on the family address for a period of twelve months, such markers are designed to help the force contact centre (FCC) to grade their response to future calls for service, and to inform officers attending those incidents of any background information relating to the address and its' occupants. The panel felt these were appropriate actions.

14.2.19 At the time of these events Charles was not in receipt of any services, save for routine contact with his GP surgery. His only known vulnerabilities were those that might be generically attributed to anyone of 90 years of age. However, for a man of advanced years he appears to have been very fit.

14.2.20 The homicide enquiry identified that Janette had some concerns that Charles might have been living with dementia not long before he died [see paragraph 12.10]. While Janette believed he needed to attend a memory clinic, it does not appear she ever articulated this to health professionals or any other agencies.

14.3 Term 3.

What was your agency's knowledge of any barriers faced by Charles that might have prevented him reporting domestic abuse and what did it do to overcome them?

14.3.1 The DHR panel did not identify any barriers within agencies in Sefton that might have prevented Charles reporting domestic abuse. He and Janette reported assaults by Thomas on two occasions [to the walk-in centre on 26 October 2018 and to the GP on 30 October]. However, it is not clear whether either Charles or Janette recognised the abuse as domestic abuse.

14.3.2 Parricide [the killing of a parent by a child] is a rare and currently neglected area of research. The DHR panel are aware of some recent research in the UK[25]. While the research provides some interesting findings it does not provide any insight into the barriers that parents may face in reporting abuse by children.

14.3.3 There is an increasing recognition within the UK of Adolescent to Parent Violence and Abuse [APVA]. An information guide published by the Home Office states[26];

'There is currently no legal definition of adolescent to parent violence and abuse. However, it is increasingly recognised as a form of domestic abuse and, depending on the age of the child, it may fall under the government's official definition of domestic abuse'.

14.3.4 The guide provides some important information to practitioners and in particular some of the barriers that parents may face. While Thomas was clearly not an adolescent when he killed his father, there was still a parent/child relationship. Hence the panel feels some of the information in this guide may be applicable in this case. His diagnosis of autism and the fact that, as an adult, he was still living in the same household as his parents meant there may still have been more of an adolescent to parent relationship rather than an adult child to parent one.

14.3.5 The guide states all forms of domestic abuse are under-reported and parents are, understandably, particularly reluctant to disclose or report violence from their child.

'Parents report feelings of isolation, guilt and shame surrounding their child's violence towards them, and fear that their parenting skills may be questioned

[25] Dr Hannah Bows Durham Law School: Where parricide meets eldercide: an analysis of child to parent/grandparent homicides in the UK

[26] Information Guide: Adolescent to Parent Violence and Abuse https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/732573/APVA.pdf

and that they will be blamed or disbelieved by those to whom they disclose the violence[27]'

14.3.6 Research by the panel identified only one publication specifically targeted at parents who experience abuse from adult children[28]. The publication identifies the following that may be barriers to parents reporting abuse.

- Feeling alone - that this does not happen to other parents.
- Feeling isolated or distanced from other family members and friends.
- Feeling that you want the abuse to stop not the relationship with your adult child.
- Feeling as a parent you need to protect your child regardless of their age.
- Feeling that you deserve the abuse as a punishment for things that may have happened in the past.
- Feeling scared to disclose the abuse or that the abuse should be kept a secret.
- Feeling that as a parent, you are responsible for the person your adult child has become and therefore the abuse.
- Feeling shame and guilt - that you have failed as a parent.
- Feeling pressure to keep your family together or that by seeking legal protection, you are being a bad parent.

14.3.7 There are a number of publications and research into domestic abuse among older people, although there appears to be a paucity of information that specifically references the abuse of elderly people by their children. As far as domestic abuse among older people is concerned, there can be many reasons they remain in an abusive relationship rather than leaving. Research[29] shows that older victims of abuse are likely to have lived with abuse for prolonged periods of time before seeking help. Physical health and dependency for others to care for them as well as isolation can all be factors in the decision made by older victims of abuse to remain[30]. The panel has not been able to identify if any of the factors in the preceding paragraphs applied in this case.

14.4 Term 4.

What knowledge did your agency have of Charles' and Thomas' physical and mental health needs and what services did you

[27] Op cit P5
[28] Adult Child to Parent Violence and Abuse: Belfast Area Domestic and Sexual Violence and Abuse Partnership https://nipsa.org.uk/attachments/article/268/Adult_to_Parent.pdf
[29] Safe Later Lives: Older people and domestic violence and abuse: Safelives Ending Domestic violence and abuse #Oct 2016
http://safelives.org.uk/spotlight-1-older-people-and-domestic-abuse
[30] ibid P14

provide? Was Thomas living with Asperger syndrome or any other diagnosed condition?

14.4.1 Charles had regular contact with his GP, all of it for routine matters that might be associated with a man of his age. He was not in receipt of any specialist services in connection with either his physical or mental health. There was no suggestion from the information provided to the review that Charles suffered from any mental health issues. Janette did mention, when seen by the police following the homicide, that Charles may have started to develop what she felt were dementia related issues. However, this was never reported to a clinician. One of the reasons being that Janette felt Charles would never have consented to a memory test.

14.4.2 Thomas' GP surgery told the DHR they reviewed his medical records in line with the terms of reference. There was no information that was relevant to the terms of reference for the DHR. It does not appear that Thomas received any services for his mental health.

14.4.3 The last record that is available that related to this issue was when he was discharged from the care of specialist services at Alder Hey Hospital in November 2014. At that time he is described as having Asperger's Syndrome. The letter from the paediatric clinic to the GP speaks of Thomas 'doing well'. There is no recommendation within the letter for any ongoing referrals to services.

14.4.4 The only agency after that point that recognised Thomas may have been living with mental health issues [before his arrest] was an officer from Merseyside Police who attended a domestic abuse incident at address 1 on 18 August 2018 [see paragraph 13.3.6]. The officer correctly completed a VPRF and the incident was risk assessed and graded as bronze. The officer signposted Charles to the force's web site where details of support for victim's is available. There is reference on the report that Thomas suffered from Asperger's Syndrome. In response to a request from the panel Merseyside Police checked their systems and found a referral to mental health services was not made on this occasion.

14.4.5 The panel asked Merseyside Police to review the decision not to make a mental health referral on this occasion. The force responded and told the panel that, generally speaking, having Asperger's Syndrome alone is not a mental health concern. Consequently, unless something was manifesting as an 'unmet' mental health need, then the force would not ordinarily make a referral. If the subject was a child, the force might make a notification to the Children with Disabilities team [via social care]. If the person was an adult then a referral to adult social care might be considered.

14.4.6 Asperger's syndrome, on its own, would not be grounds for the force to make a referral. There would need to be something else that raised the level of need to the threshold for social care. It therefore seems to the panel that on

this occasion it was an appropriate decision not to make a referral in respect of Thomas and was in line with Merseyside Police's policy

14.4.7 The next reference by a professional to Thomas' mental health was when he was examined by a clinical psychologist instructed by his defence team. This psychologist concluded that Thomas suffered from Autism Spectrum Disorder which had been present since childhood. They also concluded that Thomas may have a co-morbid diagnosis of personality disorder with some border line features [although it was difficult to say if these were distinct from his Autism Spectrum Disorder]. He was also found to be living with anxiety and a generalised anxiety disorder.

14.4.8 The psychologist could not find any record of a diagnosis of Asperger's Syndrome in Thomas' medical records although they were told by both Anna and Thomas himself about the diagnosis. The psychologist explained that [since 2013] Asperger's Syndrome is considered to be subsumed under the diagnosis of Autism Spectrum Disorder. The major difference between the two conditions is that speech is delayed in the latter: a feature of Thomas' early life. Hence the certainty of the clinical psychologist's diagnosis.

14.4.9 The [very lengthy] psychology report examines aspects of Thomas' life in great detail. The report is not repeated here as it is unnecessary to go into that level of detail. However, there were some areas the panel feel should be included. One finding from the report is that Thomas did not receive adequate care or parenting as a child. Due to the social difficulties associated with his autism, and the culture within his family and the area he lived, he was never able to recognise what was unacceptable. Because of his childhood experiences, in addition to his autism, it appears Thomas developed psychological difficulties that left him vulnerable to mental health issues.

14.4.10 The psychology report says it appears Thomas learnt from Charles in his early years that, the way he solved problems or reacted to others that annoyed him, was to be aggressive and violent. This then developed into the pattern of behaviour for resolving difficulties between father and son.

14.4.11 The panel heard there are recognised links between mental health and domestic homicides. For example, in 2016 the Home Office conducted research[31] into domestic homicides and reviewed 40 cases of which 7 involved familial homicide. Six of those cases involved a son killing a parent. Mental health issues were factors in all 7 cases.

14.4.12 Parricide is the killing of a parent. In Parricide: A review of the theory and literature[32] Holt A. suggests that, while there have been significant advances

[31] Domestic homicide reviews: Key findings from analysis of domestic homicide reviews: Home Office December 2016

[32] Holt A. [2017] Parricide in England and Wales 1977-2012: an exploration of offenders, victims, incidents and outcomes. *Criminology and Criminal Justice* 1748895816699332.

in the ways in which domestic abuse is tackled, there has been little said about parricide. Holt drew on nationally collated data from the Homicide Index and undertook analysis that focussed upon trends over the last 36 years.

14.4.13 Holt found that kicking or hitting was the method of killing in only 10% of parricides carried out by male perpetrators. Only 1% of parricides that occurred between 1977 and 2012 were because of 'other financial gain' [e.g. not connected to domestic abuse]. In 53% of the 622 cases recorded the victim was a father killed by a son. The mean age of the victim in these cases was 60. Holt states the 70 years and over age range is considered to be a low-risk group in terms of overall homicide rates.

14.4.14 The DHR review considered what these facts meant when applied to the homicide of Charles by Thomas. The panel concludes that the features of this case [i.e. the age of Charles, the use of force and the circumstances of the homicide], suggest the homicide of Charles by Thomas did not follow the trends identified in Holt's review. In addition there is evidence from the psychology report, completed as part of his court appearance, that Thomas was vulnerable to mental health issues. That runs contrary to one of Holt's findings; that most parricides are not the product of mental illness.

14.4.15 The review wonders why Thomas did not come to the attention of any agencies for some sort of disruptive behaviour in the years before he killed his father. Yet there was no record of Thomas being disruptive or violent at school or college. He was not known to the police, had no criminal record and as far as can be ascertained, had never been arrested. There was nothing in his medical records that is of any relevance to this review. There was no evidence that he behaved violently to anyone other than his father. If he had a violent or disruptive personality or reputation it is very unlikely, for example, that he would have been selected to work as a steward at Liverpool FC, a role he was said to thoroughly enjoy.

14.4.16 The panel feel that, in trying to understand Thomas' behaviour, the findings within the psychology report are important. That report looked at whether Thomas was quick to violence in any situation and if so when and how he reacted. The report concluded that Thomas did not have a propensity for violence or that he would choose violence as a means of managing a situation. It appeared to be the case that the relationship with his father had been one of aggression and abuse. Thus, Thomas' aggression and violence appeared likely to be confined to the relationship he had with his father. Rather than it being used to resolve situations with others. It was the opinion of the psychologist involved that Thomas posed a low risk of violence to the public.

14.4.17 The review panel concurred with this view. They felt Thomas' antecedents and patterns of behaviour were such that it was entirely unforeseeable that he would go on to commit a homicide.

14.5 Term 5

What knowledge or concerns did the victim's family, friends, colleagues and wider community have about Charles' victimisation and did they know what to do with it?

14.5.1 The homicide enquiry uncovered a number of witnesses within the community who had known the family for many years. Their testimony is included within section 12 of this report and is therefore not repeated here. It appears there were no concerns at all within the community about Charles' welfare or any risks he was being abused.

14.5.2 If there were concerns in the community, they were more about the way in which Charles behaved towards others. There is evidence he had a short temper, did not tolerate those who did not comply with his very rigid views, and had fallen out with a number of people in the community, including neighbours and his parish priest.

14.5.3 Members of the community refer to Thomas as the one who, in public settings, suffered abuse from his father. For example Charles threatening him [paragraph 12.25] and in the same paragraph Charles swearing at and slapping Thomas. It does not appear that information about such behaviour was ever disclosed to any agencies in Sefton and only came to light when the police undertook their homicide enquiry.

14.5.4 The panel cannot be certain as to why this behaviour was never reported. It maybe that those who witnessed it were reluctant to intervene or contact the authorities. They had known Charles and Thomas for many years and may have regarded what they witnessed as just another aspect of Charles's day to day behaviour.

14.5.5 There may also have been cultural and socio-economic issues at work. The panel did think that one of the observations made by Anna was interesting when she told the panel chair that, in the area of address 1, it was quite common for boys to fight with their fathers. The panel wondered whether there were socio-economic factors at work, that may have meant such behaviour was less remarkable than in other communities and therefore less likely to arouse concerns.

14.5.6 Given the knowledge there was, particularly within the community, about Charles' behaviour towards Thomas and his aggressive attitude to those with whom he had a disagreement it is appropriate here to make mention of the 'bystander approach'. This approach suggests individuals can choose to intervene to interrupt situations leading to violence. However, just as victims of domestic abuse face barriers to reporting, bystanders may face barriers in responding to violence that prevent them from acting.

14.5.7 A paper from the USA[33] suggests there are three main categories of influences that can reduce the likelihood of an individual intervening in a potentially high-risk situation. These include Personal Obstacles, Peer Influences, and Bystander Dynamics. In light of Anna's comment it may well be that, if such behaviour had become normalised in this community, then there may in turn be an element of peer influence at work which limits the likelihood that bystanders will report such behaviour.

14.5.8 Other than Janette and Anna, it does not appear Charles and Thomas had regular recent contact with wider family members. While they met occasionally at significant events, it appears the wider family regarded Charles and his behaviour as bullying and controlling. They did not appear to have any concerns or information to suggest that Thomas presented a risk to Charles.

14.5.9 Anna provided a lot of relevant information about the family and in particular the relationship between Charles and Thomas. This is set out in section 12 and is not repeated here. She describes a very unhappy upbringing for her brother at the hands of her stepfather. Anna never saw any behaviour that indicated to her that Charles was at risk of victimisation from Thomas.

14.5.10 Because Anna left home when she was 18 years of age and never returned [save for short visits to see her mother and Thomas] she is not able to provide first-hand information as to what was occurring between Charles and Thomas within the house. Anna was aware, from what her mother told her, of two fights between them [see paragraphs 12.22-3]. She did not attach great significance to these and did not realise how seriously Charles was injured.

14.5.11 Anna can only recall Charles being physically violent to her once. She now recognises that many of the other things she witnessed within the household as a child and teenager were in fact indicators of domestic abuse. Although it does not appear she recognised it at that time. It is common within families, where abusive behaviour occurs, for it not to be recognised for what it is. Family and friends will often recognise that violent conduct and physical force is wrong, however they often do not realise that other aspects of perpetrator behaviour are also wrong-particularly coercive and controlling behaviour.

14.5.12 In a survey and report conducted by Citizens Advice[34], only in the case of physical abuse, did more than half of the respondents feel confident they could recognise what was happening to someone they knew. Respondents

[33]Barriers to Bystander Interventions as Explained Through the Green Dot Strategy and the Socio-Ecological Model. Patrick Brady, MA Idaho Coalition against Sexual and Domestic Violence
https://idvsa.org/wp-content/uploads/2013/01/Barriers-to-Bystander-Interventions.pdf
[34] A link in the chain. The role of friends and family in tackling domestic violence and abuse: Imogen Parker August 2015

were also unclear about whether certain behaviour counted as abuse and also about who abuse can happen to. Even if domestic abuse is recognised, then family and friends may not engage because of its perceived sensitive and private nature.

'As victims may struggle to begin the conversation, its important friends are encouraged to overcome their anxieties and reticence and be equipped to ask about abuse if they have concerns'[35].

14.5.13 The key finding from this research is the need to 'support the supporters'.

'Encouraging friends and family to engage with abuse is not as simple as telling people they should: the majority of the public believe they would engage, but there is a gap between intention and interaction'[36]

The report calls for the equivalent of a 'green cross code' for domestic abuse that directly addresses the barriers for family and friends to intervene and which[37];

- Details [early] signs of abuse, dispels myths and moves beyond stereotypes.
- Offers strategies for asking safely.
- Shifts some responsibility onto informal networks to 'lean in' and engage.
- Encourages a positive first response disclosure.
- Signposts to information and support, both for victims and supporters.

14.5.14 The review panel have therefore identified learning and recommendations that embodies the spirit of this 'green cross code' and seeks to strengthen the support Sefton Safer Communities Partnership provides to the families and communities who live with domestic abuse [See lesson 4 and recommendations 2 & 6].

14.6 Term 6.

What knowledge did your agency have that indicated Thomas might be a perpetrator of domestic abuse and what was the response, including any referrals to a Multi-Agency Risk Assessment Conference [MARAC]?

14.6.1 A multi-agency risk assessment conference [MARAC] is a victim focused information sharing and risk management meeting attended by all key agencies, where high risk cases are discussed. The role of the MARAC is to

[35] Op Cit P35
[36] Op Cit P39
[37] Ibid

facilitate, monitor and evaluate effective information sharing to enable appropriate actions to be taken to increase public safety. In a single meeting, MARAC combines up to date risk information with a timely assessment of a victim's needs and links those directly to the provision of appropriate services for all those involved in a domestic abuse case: victim, children and perpetrator[38]. The idea started in Cardiff in 2001 and has now been adopted throughout England and Wales.

14.6.2 The risk assessment level is based on the victim answering a number of questions which are given a numerical score which corresponds to one of three levels-Bronze, Silver or Gold. Within Merseyside Police area [which covers a number of community safety partnership areas including Sefton], domestic abuse reports that are risk assessed and graded as Gold are automatically referred to MARAC. Other cases may be referred on the professional judgment of the person submitting the risk assessment.

14.6.3 For the reasons set out in section 14.5 and 14.6, agencies held no information before 2018 that Thomas might be a perpetrator of domestic abuse. It was only on 18 August 2018 that he first came to the attention of any agency as a potential perpetrator. In this case it was Merseyside Police that submitted a risk assessment [see paragraph 13.3.6]. The incident was graded as bronze, which the panel agreed was appropriate given the circumstances. That meant it was not referred to MARAC. On the facts known at the time the panel did not feel that this incident would have reached the threshold at which professional judgment would be applied and the case referred to MARAC when graded as Bronze.

14.6.4 The next occasion that agencies had concerns Thomas might be a perpetrator was on 26 October 2018 when Charles visited the walk-in centre having suffered injuries he and Janette attributed to Thomas [see paragraph 13.3.8]. The DHR panel believe the actions of the staff there [seeking consent for the sharing of information and referring the matter as a safeguarding issue to ASC] were correct and appropriate.

14.7.5 However, as already outlined within paragraphs 14.1.9-14.1.11, the walk-in centre did not identify this as an issue of domestic abuse and consequently did not consider a referral to MARAC. Similarly, neither did Adult Social Care or the GP recognise that, as well as this being a safeguarding adult case, Charles was the victim of domestic abuse. Consequently, neither did Adult Social Care nor the GP make, or consider making a referral, to MARAC. Again these issues have already been considered earlier in this report [see paragraphs 14.2.6 and 14.2.16 respectively.

14.7 Term 7.

How did your agency take account of any racial, cultural, linguistic, faith or other diversity issues, when completing assessments and

[38] https://www.reducingtherisk.org.uk/cms/content/marac

providing services to Charles and Thomas? Were they members of any faith communities and if so does that community have any information that may be of relevance to the DHR?

14.7.1 Section 10 of this report sets out the issues of equality and diversity and considers whether either Charles or Thomas should be treated as having a disability. Consequently that information is not repeated here. Thomas did not receive specialist services for his Asperger's Syndrome as most agencies did not know he suffered from this condition until after he was arrested. It appears to the panel that, once agencies became aware of Thomas' mental health issues, they treated him in accordance with the Equality Act and other relevant legislation such as the Police and Criminal Evidence Act.

14.7.2 Charles was a devout Roman Catholic. As part of this review the panel Chair and Carol Ellwood-Clarke QPM made enquiries with the Catholic Arch Diocese Safeguarding Officer and spoke to one of the two parish priests who knew Charles. His recollections are set out in paragraphs 12.14-12.16 and are therefore not repeated here.

14.7.3 The Diocesan Safeguarding Officer explained that all Catholic Diocese in England and Wales abide by the Catholic Safeguarding Advisory Service (CSAS) policies and procedures in respect of safeguarding. The Safeguarding Officer provided the Chair with a link to this manual. The Arch Diocese maintains a website that contains comprehensive information about safeguarding within the church and contact details for anyone wishing to raise concerns. The information provided covers both the safeguarding of children and vulnerable adults.

14.7.4 The Arch Diocese has a Safeguarding Commission, with an Independent lay chair who has extensive safeguarding experience through working with children and/or adults (e.g. social care, police, probation, family law or health). The Safeguarding Commission is accountable to the Archbishop and Trustees of Archdiocese of Liverpool for Archdiocesan safeguarding matters. The Commission leads on the strategic direction of safeguarding and provides independent oversight, scrutiny, advice and guidance on safeguarding matters relating to the Archdiocese and aligned religious Orders. The Commission has representatives from a number of statutory and voluntary agencies in the Merseyside area including the police and National Probation Service.

14.7.5 The DHR panel considered the information provided to them by the parish priest. Although Charles could be aggressive and awkward to deal with, it did not appear to the panel that any of the information was of such a nature that it should have led to a safeguarding referral being made by the parish priest in respect of either Charles or Thomas. The parish priest held no information that would have indicated Charles was at risk of domestic abuse. The priest appeared to have been shocked when he learned that Thomas had killed his father.

14.7.6 The DHR panel recognise that faith communities can often be important resources for victims providing them with wellbeing, a place where they can gain help, advice and support and seek further information in order to help protect them. Faith communities also have an important role in working in partnership with other agencies in responding to specific safeguarding issues. It appears to the DHR panel that in Liverpool Catholic Arch Diocese area there are well developed systems and processes for responding to safeguarding concerns that were reflected in a willingness to engage with this domestic homicide review.

14.8 Term 8.

Was debt, finance, alcohol or substance misuse an issue that was a relevant factor in relation to this DHR?

14.8.1 There is nothing of relevance relating to Thomas within health records that indicates he had any sort of alcohol or substance misuse issues. Anna told the review that, to her knowledge, her mother and Charles rarely drank alcohol and that until recently Thomas did not drink alcohol. Janette is a heavy smoker. The only information Anna had that Thomas consumed alcohol was when she was told by her mother about an incident in late 2018 [see paragraph 12.22].

14.8.2 There is a reference within agency records relating to alcohol. This was when Charles visited the walk-in centre on 26 October and said his son had assaulted him and had been drinking [see paragraph 13.3.8]. That information correlates with what Anna says she was told by her mother about Thomas having argued with his father when Thomas had been drinking. The visit to the walk-in centre resulted in a safeguarding referral being made to Sefton Council.

14.8.4 When ASC spoke to Janette by telephone she repeated the information that one of the factors that resulted in the first assault upon Charles by Thomas was the latter's excessive drinking. Because ASC made a triage decision that no further action was necessary, that information went no further. The review has already considered the way in which ASC handled the triaging of this referral at paragraph 14.2.7 et al.

14.8.5 Anna told the review that money, debt and poverty were significant issues in the household. When she was a child and teenager living at home she said she was never given any money and had to buy all of her own things. Including her own school shoes out of birthday gift money from other relatives. She said that her mother and Charles did not have an extravagant life style. The issue was that they just could not manage money well.

14.8.6 Anna recalled that one of the problems for Charles was that he really could not afford to run a car and as a result of that was left with a large overdraft. He eventually disposed of the car and was not driving at the time he died. Anna felt that Charles should not have been given credit. She also gave an

example of how the family had Sky Television yet were struggling to make ends meet. Anna said she had paid for this for a period of time and there was a 'big argument' when this stopped and the Sky subscription ceased.

14.8.7 She said the family could not budget. She felt a significant issue was her mother's ill health[39]. Because of this Janette had not worked for many years and instead received benefits. Anna said her mother struggled with making her benefits last and she tended to spend everything immediately rather than spreading it over the month. Over the last few years Anna said her mother's benefits were cut. First she lost the child allowance for Thomas as he grew older. As the benefits system changed, Janette received less income.

14.8.8 Anna said that Janette's personal independent payment [PIP] was removed for a period of time. Janette was told she should seek employment. Anna felt that was impossible because of her mother's health condition and because she had no experience of employment for many years. Although Janette's PIP was eventually restored Anna felt this was a significant issue and represented a tipping point for the incidents that followed. When Anna saw the DHR report for the first time, she commented that the removal of this vital benefit was erroneous and said she felt the Department for Work and Pensions need to be held accountable for getting this so wrong. Anna felt that, unfortunately, this is not an isolated incident, with many disabled individuals receiving zero points in their initial assessment, only to receive 15+ at a tribunal[40].

14.8.9 There is evidence from within the community that Charles and Janette struggled to make ends meet. For example, calling at neighbour's houses asking for money. Charles demanded credit from a local shop and became aggressive when it was refused. The parish priest also recalled Charles asking people within the parish for money [see paragraph 12.15].

14.8.10 The review recognises that financial and economic abuse can form part of a wider pattern of coercive control within the context of domestic abuse and these links are well documented. Often perpetrators will deliberately manipulate family finances so that the victim is entirely dependent upon them hence reinforcing the perpetrator's circle of coercion and control.

14.8.11 While finance is the underlying cause of the fight that broke out between Charles and Thomas, it does not seem it was part of a pattern of coercive and controlling behaviour by Thomas towards Charles. As is sometimes seen within intimate partner domestic abuse. Neither does it appear that Charles was somehow manipulating the family finances himself as part of a pattern of control. Rather, it appears that as a family, Charles, Janette and Thomas simply could not manage on the income they were receiving.

[39] When commenting upon the report Anna said she believed financial mis-management is a feature of bipolar, with sufferers experiencing 'highs' when money is spent imprudently.

14.8.12 Compounding this was the fact Thomas' girlfriend was expecting a child. Although he had periods of employment, at the time of the homicide, Thomas was unemployed and was relying upon benefits. Despite his efforts at gaining employment, he struggled to stay in work. His sister Anna feels that Thomas' learning difficulties were a significant contributory factor in him not being able to retain employment and was an underlying factor that led to the homicide [see paragraph 12.15].

14.8.13 Thomas was saving money to help contribute to the upbringing of his child. In her statement to the police following their attendance on 27 March 2019, Janette said that when Charles asked Thomas for money Thomas said the following.

"I'm sick of this, I'm always giving you's money". Do you wanna fight, do you wanna fight, that money is for my baby".

It was at that point that Thomas ran straight towards Charles and started punching him.

14.8.14 The review considered two issues in relation to this information. Firstly, were there opportunities for agencies to have identified the impact of finance and the potential link to domestic abuse and to ameliorate them? Secondly what lessons are there for agencies here and what might they do differently in the future to help prevent such tragic events as this being repeated?

14.8.15 While a detailed analysis of the socio-economic factors in the area of address 1 is beyond the scope of this report, nonetheless, it is felt relevant to highlight the fact that deprivation is a significant challenge within this local authority area.

'In its entirety it is in the most deprived quarter of English Local Authorities with five of its lower super output areas (LSOA) in the top 1% nationally[41]'

[Address 1 is situated in one of these top 1% LSOAs].

14.8.16 The most recently published Joint Strategic Needs Assessment for Sefton [2018][42] indicates some of the main health and well-being challenges include [amongst others]:

- An ageing population.
- Increasing financial pressures affecting the local authority, Clinical Commissioning Groups and other agencies.

[41] Sefton People and Place Introductory Profile: Source Sefton Council 13.2.2019 www.sefton.gov.uk/media/1533553/sefton_people_place_profile_mar19.pdf

[42] Local Health and Wellbeing Boards in England conduct a Joint Strategic Needs Assessment (JSNA) which looks at the current and future health and care needs of the local population to inform and guide the planning and commissioning (development of services) of health, well-being and social care services within the local authority area.

- Patterns of deprivation marked by isolated pockets and hidden need within communities and extremely high levels of deprivation in some core areas.
- Significant issues with historical health patterns for some of the population deriving from previous heavy industrial and manufacturing work.
- Average earnings below the national average contribute to a number of issues including food poverty, homelessness, mental health and wellbeing, and fuel poverty.
- The need for a focus on mental health and wellbeing throughout the life course with a particular emphasis on groups and geographic areas where outcomes are comparatively poor and socio-economic deprivation, and an understanding of the relationship between mental and physical health.

14.8.17 Against this background, it maybe the financial circumstances Charles and Janette found themselves in were not unique nor particularly remarkable when set against others in their community. Hence, they were unlikely to come to the attention of agencies as a family in need of emergency support. The DHR panel made enquiries with the local authority tax team and their revenue and benefits team to see if that was the case. The latter team had no record of any debts recorded at address 1.

14.8.18 The tax team informed the panel there was a debt on the property account for address 1 although this was very recent. Prior to 2017 address 1 had a full exemption both for Janette [an exemption note was on the file from her doctor] and Charles [because of his age]. From November 2017 circumstances appear to have changed [possibly in relation to Janette's benefits and subsequent PIP appeal] meaning an amount of council tax was required to be paid. This this resulted in a debt of £600, increasing to £709 by 2019.

14.8.19 However, the tax team reported that only reminder letters would have been sent to address 1 due to the notes on the file of vulnerable residents living there. Hence there was no proactive enforcement against this debt. Rather than actively seeking help from agencies it appears instead that Charles and Janette were prepared to look for a helping hand through other more informal routes, for example by seeking credit at shops, from neighbours or from the church.

14.8.20 The review panel do not know why Charles did not seek more formal opportunities for support either from statutory or voluntary agencies. For a number of year he volunteered for the St Vincent de Paul Society, a charity that helps those in need, and was therefore likely to understand better than others what avenues are available to those in financial need. When reading the DHR report for the first time Anna commented that one of the reasons

the church may not have referred Charles to this Society was that it relies upon volunteers who are in short supply.

14.8.21 The review panel only identified one occasion when any agency had the opportunity to make a connection between finance and domestic abuse. This was when Merseyside Police attended address 1 on 18 August 2018 following the report of loud banging and shouting [see paragraph 13.3.6]. The officer that attended correctly completed a VFPR. This refers to the circumstances that have already been outlined in relation to the arrival of the baby and family finances. However, a question on the VFPR that related to finance as an issue was answered by Charles in the negative.

14.8.22 While Merseyside Police did not make the connection between debt and domestic abuse until after the homicide, nonetheless, they have identified there is some learning concerning this issue which is set out at paragraph 16.1.1.

14.8.23 This review cannot explain why Charles did not disclose more information about the debt issues. There may be many reasons. For example personal pride or perhaps the view taken by some elderly people that money is something that is not discussed outside the household and certainly not with strangers. It may be that, after living in the same community for many years, and just making ends meet, Charles did not consider debt was a significant issue.

14.8.24 Finally, in relation to lessons for the future in respect of debt, the review panel did not identify any significant gaps in respect of domestic abuse. The health and well-being challenges within the area of address 1 are very well recognised by agencies and are clearly set out in strategic and planning documents such as the Joint Strategic Needs Assessment. Agencies such as the local authority and health recognise these challenges and appear to be trying to configure their services in response to them. For example, the local authority has an emergency limited assistance fund available to help people with expenses such as food, gas electric and white goods. In 2016/17 there were 8,680 applications for this fund.

14.8.25 There is also active voluntary and community sector involvement in Sefton area. For example Sefton Citizens Advice have a dedicated money and debt advice line that is available five days each week. Sefton Council web site contains information about IVAorg a non-fee charging, 'not-for-profit' organisation which specialises in providing confidential, free and impartial advice to anyone experiencing problems with their unsecured debts. In addition to debt advice there are also a number of foodbanks located in the Sefton area that are operated by charities.

14.8.26 The challenge for agencies both statutory and voluntary may well be understanding why some people will not access these services and need more doing to encourage them to do so.

14.9 Term 9.

Did your agency follow its domestic abuse policy and procedures, and the multi-agency ones?

14.9.1 Merseyside Police did recognise domestic abuse on 18 August 2018 and adhered to their domestic abuse policy and procedure when responding. There were some occasions when policy and procedures were not followed. These have already been identified and discussed earlier in the report as follows:

- The walk-in centre did not identify the presentation by Charles was both domestic abuse as well as a safeguarding issue [paragraph 14.1.9].
- Adult Social Care's response to the receipt of the safeguarding referral from the walk-in centre did not recognise this was a case of domestic abuse [paragraph 14.2.7].
- The GP did not identify this was a case of domestic abuse and did not take more immediate action to protect Charles by escalating the issue for example by reporting it to the police [paragraph 14.2.15].

14.10 Term 10.

Were there issues in relation to capacity or resources in your agency that impacted on its ability to provide services to Charles and Thomas, or on your agency's ability to work effectively with other agencies?

14.10.1 The DHR panel did not identify any issues in relation to statutory agency capacity or resources that impacted upon this review. However, the panel do feel that work needs to be undertaken to identify if a gap exists for services to male victims of domestic abuse. Historically, services have been configured to cater for the needs of women and children who have, and continue to, represent the majority of the victims of domestic abuse. It is unclear whether Charles recognised he was a victim of domestic abuse [and also a perpetrator] and if so whether he recognised he needed help. Nonetheless, this is now the second domestic homicide within the Sefton area in which the victim has been male and hence represents an opportunity to take stock of such provision. [see recommendation 3].

14.11 Term 11.

What learning has emerged for your agency?

14.11.1 Agency and panel learning emerging from this review is outlined at section 16 below.

14.12 Term 12.

Are there any examples of outstanding or innovative practice arising from this case?

14.12.1 The panel did not identify any outstanding or innovative practice in this case.

14.13. Term 13.

Does the learning in this review appear in other Domestic Homicide Reviews commissioned by Sefton Community Safety Partnership?

14.13.1 This is the eighth domestic homicide to have taken place in Sefton since 2012. Four of these cases [including the case of Charles] involve familial homicides in which there was no intimate relationship between the victim and perpetrator.

14.13.2 There are lessons within two of these four familial domestic homicide reviews which this DHR panel feel correspond to similar learning in the case of Charles. In Sefton DHR 4, Kathleen was killed by her daughter Louise. This review found there were lessons in relation to the following:

- Failure to recognise when the serious nature of a crime committed or suspected overrides the confidentiality wishes of a vulnerable person and means that policies on abuse are not correctly applied thereby denying agencies the opportunity to assess and address abuse.

- This case highlighted that professionals need to understand there are different aspects to domestic abuse. These include controlling behaviour that does not always present in the context of an intimate relationship between a male and a female.

14.13.3 In Sefton DHR 5 Nathanial was killed by his brother Kristian. This review found there was a lesson in relation to the following:

- [Nathaniel and Kristian were raised in a household in which they were exposed to domestic abuse. Both experienced violence as children] Examination of the family history of Nathaniel and Kristian show these behaviours were well embedded many years ago.

14.13.4 In these two cases in which there is a cross-over of learning, the DHR panel in this case has avoided repeating the same recommendations and instead has recommended Sefton Safer Communities Partnership revisits the original recommendations to ensure they have been embedded within practice. [see recommendation 1].

15. CONCLUSIONS

15.1 This DHR is about the manslaughter of Charles. He is, and always will remain, the victim of this domestic homicide. No matter how aggrieved Thomas was, he killed his father in circumstances that amounted to a criminal offence for which he has been punished by the courts. As the sentencing judge recognised in his comments, Thomas must have realised he should not have repeatedly punched his father.

15.2 However, in trying to understand what happened in this case it is not possible to avoid the fact that Charles was also a perpetrator of abuse towards Thomas. His life, as described by Anna, was terrible. From his early years he was affected by domestic abuse between Janette and Charles which appears to have been the result of Janette's mental illness.

15.3 Although these events occurred many years ago, there is clear evidence of multi-agency intervention and joint working by the police, health, children's social care and the community/voluntary sector to support the family, and particularly Thomas. These efforts appeared, on the face of them, to be successful in that Janette's illness was treated and normality returned to the household and agencies withdrew. The panel identified a lesson in respect of the exposure of children to domestic abuse and the normalisation of such behaviour and its impact upon their behaviour in later life.

15.4 While on the surface, there were no further crisis calls to agencies, it is clear Thomas' life was far from normal. He was diagnosed with Asperger's Syndrome which had an impact upon his learning and his behaviour. While Janette describes Thomas' relationship with his father as 'on and off' most of the evidence the panel has seen indicates Thomas suffered physical, verbal and emotional abuse from Charles. This was witnessed both by Anna and by members of the community. However it remained hidden from agencies.

15.5 Why Charles behaved in this way is unclear. There appeared to be two different aspects to his character. On the one hand he was a devout Catholic, a regular attender at holy mass, a former alter server, and a former member of St Vincent de Paul Society. On the other hand he appears to have had an intolerance of people who did not worship, castigated an unmarried mother, threatened a neighbour with a knife and generally had a reputation as a bully and an unpleasant man.

15.6 While there are examples from Janette that Charles and Thomas shared some of the traditional father and son pastimes, it also appears the behaviour of Charles had a profound effect upon Thomas. As stated in the psychology report, because of his childhood experiences in addition to his autism, it appears Thomas developed psychological difficulties that left him vulnerable to mental health issues. Thomas learnt from Charles in his early years that,

the way he solved problems or reacted to others that annoyed him, was to be aggressive and violent. This then developed into the pattern of behaviour for resolving difficulties between father and son. Some people in the community saw what Charles did to Thomas; they did not report what they saw. There may be many reasons why that did not happen, including that such behaviour might have been normalised in that community. The panel has made a recommendation in respect of empowering 'bystanders' to respond to such behaviour.

15.7 It is this feature of Thomas' personality that appears to have been the reason why he reacted the way he did, when he struck his father when they argued over money. In all other respects, Thomas appears to have been a mild mannered and well-behaved individual. He had never been arrested and was not known to the police or other agencies until very shortly before this incident. Indeed Thomas' antecedents and patterns of behaviour were such that the panel feel it was entirely unforeseeable that he would go on to commit this homicide.

15.8 Although Charles and Thomas remained largely unseen to agencies, there were some opportunities to engage with them before the final and fatal event. The first of these was when OVH visited address 1 following reports of fighting there on 9 August 2018. The DHR panel felt their response was appropriate as was the decision not to treat the matter as domestic abuse.

15.9 Another opportunity for engagement occurred on 18 August 2018 when the police were called to reports of shouting and banging at address 1. In the view of the panel the decision of the police to record this as domestic abuse and grade it as 'bronze' was appropriate. This was the first time that any agency received information there were tensions between Thomas and his father.

15.10 As the victim on this occasion Charles was asked if debt was an issue and he replied that it was not. Consequently, there were no referrals nor was the information about the event shared with other agencies. Had debt been an issue Merseyside Police would have advised Charles to seek assistance from agencies such as Citizens Advice Bureau[43]. Again, the panel take the view the actions of the police were appropriate in respect of the information they had available to them.

15.11 The event of 26 October 2018, when Charles visited the walk-in centre with injuries caused by Thomas was a missed opportunity for agencies to act. While the walk-in centre correctly referred the matter to ASC, they did not recognise this was also a case of domestic abuse and did not complete a risk assessment.

[43] While Merseyside Police do not have a pathway for referring people in financial difficulty they told the DHR panel the information gleaned regarding finances and debt would assist in the formulation of an overall risk assessment and subsequent interventions.

Similarly when ASC triaged the referral they did not treat the matter as domestic abuse. There were clear indicators from what Janette said, that indicators associated with domestic abuse were present, including misuse of alcohol by Thomas and debt within the family. The panel has identified a lesson in relation to the recognition of debt as a factor in domestic abuse.

15.12 The panel believe this case demonstrates a theme in other DHRs and SARs. That is, agencies make referrals to adult social care without taking any other action when they could have referred the individual to other support services or processes. The expectation in some cases appears to be that, once a referral to adult social care has been made, the referring agencies responsibility ends. The issue here appears to be that some agencies do not recognise that domestic abuse does not always present within the context of intimate male and female relationships. These are important learning points from this review. They also lead the panel to conclude that it would be timely to review the demand for, and provision of, services for male victims of domestic abuse.

15.13 By the time the GP attended to Charles on 25 March 2019 the final, and ultimately fatal, fight between him and Thomas had already happened. While the GP correctly made an adult safeguarding referral, like the walk-in centre and ASC, the GP did not recognise this was also a case of domestic abuse. More importantly the GP, like ASC, did not realise there was a need for more immediate action to be taken to protect Charles from further harm [Thomas was still in the house] and to report what was a serious offence to the police. The police only became aware two days later when an anonymous caller reported the matter. There is a further important learning point here, that has been found in other DHRs, about the need for agencies to recognise when more immediate action is needed in response to serious events.

16. LESSONS IDENTIFIED

16.1 Agencies Lessons

16.1.1 Merseyside Police

- Merseyside Police is committed to reducing domestic abuse by improving the way it supports victims and families. Financial hardship places additional strain on relationships often already under pressure for other reasons. The right questions need to be asked to establish if this is the case, primarily, was the incident triggered by the financial predicament of any of the involved parties? If the answer is yes that party should be signposted to an agency such as the Citizens Advice Bureau (CAB) for financial advice and support. In this case, the information was only known to police in the context of 'domestic abuse' after the assault on 27th March 2019. Signposting after that date would not have changed the outcome for this family but adopting this as good practice may prevent similar incidents in future.

16.1.2 North West Boroughs Healthcare NHS Foundation Trust

- The walk-in centre identified a safeguarding concern and engaged Charles to seek consent to make a safeguarding referral. Concerns were acted on within a timely manner. Charles continued to be seen by walk-in centre staff in spite of attempts to redirect him to the Treatment Rooms where he could have identified appointment slots which are longer in duration. Charles felt comfortable with walk-in centre staff to continue to attend for treatment.

16.1.3 GP Surgery

- The practice Safeguarding Adult Policy needs to be updated and compliant with the Care Act 2014. To include local procedures of what to do when an incident occurs.
- The practice Domestic Abuse Policy needs to be updated and compliant with the Home Office, 2014. To include local procedures of what to do when an incident occurs.
- Practice post event learning to take place on the recognition of domestic abuse in older people.
- Practice post event learning to take place to ensure practitioners establish whether victims of domestic abuse are at immediate risk of harm.

16.1.4 **Sefton Adult Social Care**

- Screening of adult safeguarding needs to be robust and closely supported via the safeguarding team.

16.2 The Domestic Homicide Review Panel's Lessons

16.2.1 The DHR panel identified the following lessons. Each lesson is preceded by a narrative which seeks to set the context within which the lesson sits. When a lesson leads to an action a cross reference is included within the header.

Lesson 1 [Panel recommendation 1,2 and 5]
Narrative
Thomas had a troubled childhood. His mother suffered from mental illness and this in turn led to Thomas witnessing domestic abuse within the household. There were concerns about the impact of this behaviour upon Thomas who was made the subject of a child protection plan. Although his mother's mental health settled, as a couple Charles and Janette appeared to struggle as parents. There is evidence from many people, including his sister, that Thomas continued to be exposed to violent, coercive and controlling behaviour at the hands of Charles throughout the remainder of his childhood and into his early adult years.
Lesson
Children that are raised in households in which they are exposed to domestic abuse may in turn have some of those behaviours embedded and/or normalised within their own behaviour.

Lesson 2 [Panel recommendation 3 and 6]
Narrative
Debt and financial issues were a significant feature for the whole family in this case. Both Charles and Janette had difficulties in managing their finances. Janette suffered financially when her benefits were reduced. Because of her mental illness she was not able to work. Charles and Janette turned to informal means of support such as asking for loans from members of their local community and from their church. Thomas faced financial challenges as well. His autism spectrum disorder meant that he had difficulty finding and remaining in employment. What little money he had he was trying to save towards supporting his unborn child. When Charles started to ask Thomas for money this was a significant factor that led to Thomas then assaulting his father.
Lesson
There are well documented links within previous cases of intimate domestic homicide and debt and financial issues. Very often perpetrators

will use financial and economic abuse as a means of exercising coercive and controlling behaviour their victims. While that is not the case here, the manslaughter of Charles demonstrates that debt and financial issues can also be factors within familial domestic abuse and homicide.

Lesson 3 [Panel recommendation 2, 5 and 6]
Narrative
Charles was the victim of domestic abuse on a number of occasions. On 18 August 2018 Merseyside Police attended address 1 following a call about loud banging and shouting. They identified Charles as the victim of domestic abuse and correctly documented this. On 26 October 2018 Charles presented at the walk-in centre with injuries he said were caused by Thomas. The walk-in centre identified this as a safeguarding adult case and made a referral to ASC. Neither ASC nor the walk-in centre recognised this was also domestic abuse. On 25 March, Charles' GP was told that he had been assaulted by Thomas. The GP made an adult safeguarding referral; however they did not recognise this was also a case of domestic abuse. Neither the walk-in centre, ASC nor the GP completed a risk assessment.
Lesson
Professionals need to understand there are different aspects to domestic abuse and that it does not always present in the context of an intimate relationship between a male and a female. Failure to recognise domestic abuse means opportunities are lost to identify and respond to the risk victims face.

Lesson 4 [Panel recommendation 2 and 6]
Narrative
Thomas was also the victim of domestic abuse at the hands of Charles. This included both verbal and physical abuse. On occasions this took place within the home and sometimes it took place in the street. His behaviour was witnessed by Anna and also by members of the community. Charles was also said to have shouted at Janette on occasions demanding she come home. Some family members said Charles was a bully and that he was controlling. Charles' abusive behaviour towards Thomas was never reported to any agency. The comments made by Anna, that in this community it is common for fathers to fight with their sons, suggest behaviour like this might have become normalised for some members of the community.
Lesson
Family members and 'bystanders' in the community sometimes have valuable knowledge about domestic abuse. They do not repeat that for a

variety of reasons. Those factors might include barriers within the community because some behaviours have become normalised. Empowering them to say something and to know where they can share information will improve safety and outcomes for victims.

Lesson 5 [Panel recommendation 2 and 6]
Narrative
On 26 October 2018 Sefton ASC received information via a safeguarding adult referral made by the walk-in centre that Thomas had assaulted Charles. They did not take any steps to ascertain with Charles whether that information could be shared with other agencies including the police. On 25 March 2019 Charles' GP received information that he was the victim of a more serious assault by Thomas. The GP attended to administer treatment and made an adult safeguarding referral. They did not report the assault to the police nor did they take more immediate action to safeguard Charles from further harm by Thomas.
Lesson
Failure to recognise when the serious nature of a crime committed or suspected overrides the confidentiality wishes of a vulnerable person means they may face continuing risk and are not adequately protected from risk.

17. RECOMMENDATIONS

17.1 Agencies Recommendations

17.1.1 The agencies recommendations are set out within tables at Appendix C.

17.2 The Panel's Recommendations

17.2.1 The DHR panel identified the following recommendations.

Number	Recommendation
1	Sefton Safer Communities Partnership revisits the recommendations arising from the deaths of Kathleen and Nathanial and looks for evidence that the recommendations have been embedded in policy and practice.
2	Sefton Safer Communities Partnership improves the response to domestic abuse by ensuring the following areas of policy and practice are effectively applied; a) Professionals recognising when the serious nature of a crime committed or suspected means it should be reported to the police immediately. b) Professionals' recognition of domestic abuse and that it does not always present in the context of an intimate relationship between a male and a female and what to do when it is identified. c) The impact and response to the exposure of children to domestic abuse and what might happen when they reach adulthood. d) Increasing family and 'bystander' knowledge of domestic abuse and what they should do with such information for example the promotion of a green cross code.
3	Sefton Safer Communities Partnership considers how it can improve the way in which services are provided to victims of domestic abuse who may also face issues of debt by ensuring the links between domestic abuse and debt is recognised by professionals in agencies when delivering services.
4	Sefton Safer Communities Partnership considers how it can improve the way in which services are provided to male victims of domestic abuse by reviewing the need for, and availability of such services.
5	Sefton Adult Social Care should consider reducing the risk of vulnerable adults becoming victims of domestic abuse by providing regular progress reports to Sefton Safer

	Communities Partnership on its work to improve the links between safeguarding adults and domestic abuse.
6	Sefton Safer Communities Partnership ensure the knowledge of professionals in partner agencies is improved about the risks of domestic abuse by sharing the learning from this review, for example through a learning event or a briefing document.
7.	To ensure all agencies that have contributed to this review are held accountable for improving the response to domestic abuse they should all report on their progress with implementing their action plans to Sefton Safer Communities Partnership

Appendix A

Definition of Domestic violence and abuse

Domestic violence and abuse: new definition

The cross-government definition of domestic violence and abuse is:
any incident or pattern of incidents of controlling, coercive, threatening behaviour, violence or abuse between those aged 16 or over who are, or have been, intimate partners or family members regardless of gender or sexuality. The abuse can encompass, but is not limited to:

- psychological
- physical
- sexual
- financial
- emotional

Controlling behaviour

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

Coercive behaviour

Coercive behaviour is an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim. This is not a legal definition.

Appendix B

Controlling or Coercive Behaviour in an Intimate or Family Relationship

A Selected Extract from Statutory Guidance Framework[44]

- The Serious Crime Act 2015 [the 2015 Act] received royal assent on 3 March 2015. The Act creates a new offence of controlling or coercive behaviour in intimate or familial relationships [section 76]. The new offence closes a gap in the law around patterns of controlling or coercive behaviour in an ongoing relationship between intimate partners or family members. The offence carries a maximum sentence of 5 years' imprisonment, a fine or both.
- Controlling or coercive behaviour does not relate to a single incident, it is a purposeful pattern of behaviour which takes place over time for one individual to exert power, control or coercion over another.
- This offence is constituted by behaviour on the part of the perpetrator which takes place "repeatedly or continuously". The victim and alleged perpetrator must be "personally connected" at the time the behaviour takes place. The behaviour must have had a "serious effect" on the victim, meaning that it has caused the victim to fear violence will be used against them on "at least two occasions", or it has had a "substantial adverse effect on the victims' day to day activities". The alleged perpetrator must have known that their behaviour would have a serious effect on the victim, or the behaviour must have been such that he or she "ought to have known" it would have that effect.

Types of behaviour

The types of behaviour associated with coercion or control may or may not constitute a criminal offence. It is important to remember that the presence of controlling or coercive behaviour does not mean that no other offence has been committed or cannot be charged. However, the perpetrator may limit space for action and exhibit a story of ownership and entitlement over the victim. Such behaviours might include:

- isolating a person from their friends and family.
- depriving them of their basic needs.
- monitoring their time.
- monitoring a person via online communication tools or using spyware.
- taking control over aspects of their everyday life, such as where they can go, who they can see, what to wear and when they can sleep.

[44] Controlling or Coercive Behaviour in an Intimate or Family Relationship Statutory Guidance Framework. Home Office 2015

- depriving them of access to support services, such as specialist support or medical services.
- repeatedly putting them down such as telling them they are worthless.
- enforcing rules and activity which humiliate, degrade or dehumanise the victim.
- forcing the victim to take part in criminal activity such as shoplifting, neglect or abuse of children to encourage self-blame and prevent disclosure to authorities.
- financial abuse including control of finances, such as only allowing a person a punitive allowance.
- threats to hurt or kill.
- threats to a child.
- threats to reveal or publish private information [e.g. threatening to 'out' someone].
- assault.
- criminal damage [such as destruction of household goods].
- rape.
- preventing a person from having access to transport or from working.

This is not an exhaustive list

Appendix C

Agency Action Plans

Sefton Council Adult Social Care

Nº:	Recommendation	Key Actions	Evidence	Key Outcomes	Lead Officer	Date
1.	Reinforce use of the Dash risk assessment tool for all DA referrals	Liaise with IDVA team to present this to team again and include discussion	Minutes of meetings , emails , training materials, new pathway	Increased knowledge across the dept. Ensure that all DA contacts are checked	Janice Lee-Croll	Immediate by email and latterly by Nov 2020
2.	All DV referrals from Call Centre/emails to be screened via safeguarding team members	Currently in place but to be formalized via new Safeguarding business model to ensure appropriate level of resource (staffing) committed to achieve robust practice	New business model pathway devised and shared.	Improved risk assessment at front door and accurate signposting.	Janice Lee-Croll	Target date March 2021
3.	Ensure all team members receive DA training via module on-line and via course attendance at training unit – post covid.	Ensure PLDR (professional learning and development review) process checks completion of this module and	Supervision/PLDR documentation. Principle Social worker – SGA manager to check on progress of protected study time	Increased knowledge base, closer liaison and partnership work with DA advocacy services .	All management team (Safeguarding Adults) in liaison with Sefton Training unit.	March 2021

		related relevant material (supervision by line manager)	to achieve appropriately trained and knowledgeable staff in the dept.			

Merseyside Police

Nº:	Recommendation	Key Actions	Evidence	Key Outcomes	Lead Officer	Date
1.	Officers should explore 'financial hardship' as a causative factor in cases of domestic violence and abuse and to signpost to support services such as Citizens Advice Bureau.	Delivery of training – to be included within the rolling program of Protecting Vulnerable People. Information included in newsletters across all Strands within the Force so all officers are made aware. This will include first responders	Training material Newsletter	Increase in the identification of incidents where financial hardship was a causative factor and signpost to support services.	DCI Bev Hyland	January 2021

GP Surgery

Nº:	Recommendation	Key Actions	Evidence	Key Outcomes	Lead Officer	Date
1.	In situations of domestic violence and abuse, GP Practice staff to directly question whether individuals are at immediate risk of harm and document within the patient records as evidence of assessment of risk	Practice to include in the Practice Learning Time Events. To incorporate within the Practice Safeguarding and Domestic violence and abuse Policy and Procedures CCG to highlight at the CCGs GP Safeguarding Leads Meeting to disseminate learning across all GP practices	Agenda from the practice Learning Time event Updated Safeguarding Policy and Procedure Agenda CCG's GP Safeguarding leads meeting	Increased assessment of risk as part of safeguarding / domestic violence and abuse incidents	GP Safeguarding Lead Glovers Lane Practice	January 2021

Nº:	Recommendation	Key Actions	Evidence	Key Outcomes	Lead Officer	Date
2.	GP Practice Domestic violence and abuse Policy to be reviewed and updated in line with Home Office domestic violence and abuse guidance (2016), to include local procedures of what to do at a Practice level.	GP Practice Domestic violence and abuse Policy and Procedures to be revised in line with Home Office guidance. GP practice staff are aware of the updated policy and changes to policy	Policy and procedures in place. Policy and procedure have been discussed that the practice protected learning time. Flow chart in place and available for practice staff to follow on 'what to do'	Increased awareness that older people can be at risk of domestic violence and abuse / violence from family members and to take appropriate action.	GP Safeguarding Lead Glovers Lane Practice	January 2021
3.	GP Practice Safeguarding Adult Policy to be reviewed and updated in line with Care Act, Care and Support statutory guidance (2014), to include local procedures of what to do at a Practice level.	GP Practice Safeguarding Adult Policy and Procedures to be revised in line with Care Act statutory guidance GP practice staff are aware of the updated policy and changes to policy	Policy and procedures in place. Policy and procedure have been discussed that the practice protected learning time. Flow chart in place and available for practice staff to follow on 'what to do'	Increased awareness of the categories of abuse for adults as per the care act.	GP Safeguarding Lead Glovers Lane Practice	January 2021

Nº:	Recommendation	Key Actions	Evidence	Key Outcomes	Lead Officer	Date
4.	Training / Awareness raising to be undertaken at a practice level and across Sefton GP Practice's to ensure that GP practice staff are able to recognise domestic violence and abuse and violence in all its guises and take appropriate action.	To include domestic violence and abuse / violence in older people at the next Practice protected learning time event To include domestic violence and abuse in older people at the next CCG Practice protected learning time event	Agenda for the Practice Learning Time Event Agenda at the CCGs Safeguarding Business Meeting Agenda for the CCGs GP Practice Learning Time Event	Increased awareness that older people can be at risk of domestic violence and abuse from family members	GP Safeguarding Lead Glovers Lane Practice Tracey Forshaw Assistant Chief Nurse South Sefton & Southport and Formby CCG	January 2021

North West Boroughs Healthcare NHS Foundation Trust

Nº:	Recommendation	Key Actions	Evidence	Key Outcomes	Lead Officer	Date
1.	Review of awareness of domestic violence and abuse signs/symptoms and processes with walk-in centre staff.	Audit on staff awareness to understand any gaps.	Audit outcome	Assurance that walk-in centre staff are knowledgeable on domestic violence and abuse signs/symptoms. Identification of any further training needs.	Sarah Shaw - NWBH	April 2020.

DHR Panel Action Plans

DHR Panel Recommendations							
No	**Recommendation**	**Scope local or regional**	**Action to take**	**Lead Agency**	**Key milestones achieved in enacting recommendation**	**Target Date Completion**	**Completion Date and Outcome**
1.	Sefton Safer Communities Partnership revisits the recommendations arising from the deaths of Kathleen and Nathanial and looks for evidence	Local	Review of actions completed in relation to DHRs 4 and 5	Sefton DA Steering Group	Completion of review Outcomes fed back to SSCP	December 2020	

	that the recommendations have been embedded in policy and practice.						
2.	Sefton Safer Communities Partnership improves the response to domestic abuse by ensuring the following areas of policy and practice are effectively applied; a) Professionals recognising when the serious nature of a crime committed or suspected means it should be reported to the police immediately. b) Professionals recognition of domestic abuse and that it does not always present in the context of an intimate relationship between a male and a female and	Local	Review existing Sefton DHR action plans Review other Merseyside DHR learning outcomes and actions	Sefton DA Steering Group	Completion of review Outcomes fed back to SSCP Any further actions resulting from the review are agreed	November 2020 December 2020	

	what to do when it is identified. c) The impact and response to the exposure of children to domestic abuse and what might happen when they reach adulthood. d) Increasing family and 'bystander' knowledge of domestic abuse and what they should do with such information for example the promotion of a green cross code.						
3.	Sefton Safer Communities Partnership considers how it can improve the way in which services are provided to victims of domestic abuse who may also face issues of debt by ensuring the links between domestic abuse	Local and regional	Agencies to consider how their own DA training covers the links between debt and abuse and update if required	Sefton DA Steering Group	Feedback to DA steering group from agencies on their review of DA training and inclusion of info on links to debt 7 minute briefing produced and shared	January 2021 October 2020	

	and debt is recognised by professionals in agencies when delivering services.		Develop a 7 minute briefing on links between DA and debt as risk indicator	Sefton Council	across Sefton partnerships		
	Sefton Safer Communities Partnership considers how multi-agency training on domestic abuse includes abuse/violence in older people.	Local	Agencies to consider how their own DA training includes violence and abuse against older people and also within a family context.	Sefton DA Steering Group	Feedback to DA steering group from agencies on their own DA training.	January 2021	
4.	Sefton Safer Communities Partnership considers how it can improve the way in which services are provided to male victims of domestic abuse by reviewing the need for, and availability of such services.	Local	Incorporated within Sefton's DA Strategy work and Systems review	Sefton DA Steering Group	Multi agency systems review completed	November 2020	

5.	Sefton Adult Social Care should consider reducing the risk of vulnerable adults becoming victims of domestic abuse by providing regular progress reports to Sefton Safer Communities Partnership on its work to improve the links between safeguarding adults and domestic abuse.	local	Quarterly updates provided shared with SSCP Continued Communities representation on Sefton's Care Governance group	Sefton Council: Communities	Adult Social Care /Safeguarding updates Agenda/minutes of Sefton's Care Governance Group	From December 2020	
6.	Sefton Safer Communities Partnership ensure the knowledge of professionals in partner agencies is improved about the risks of domestic abuse by sharing the learning from this review, for example through a learning event or a briefing document.	Local and regional	Key lessons and recommendations shared across partnerships Learning case study produced and shared across agencies. Agencies to discuss with workforce		Learning case study produced Agencies report back to Sefton DA Steering group as to how case learning has been shared and any actions implemented as a result Case learning and recommendations shared with Sefton's	September 2020 January 2021 September 2020	

					Adult Safeguarding and Care Governance Group Case learning and recommendations shared with Sefton LSCB, Merseyside Safeguarding Adults Board, other Merseyside CSPs and with Merseyside Strategic Domestic Violence Group	December 2020	
7.	To ensure all agencies that have contributed to this review are held accountable for improving the response to domestic abuse they should all report on their progress with implementing their action plans to Sefton Safer Communities Partnership	Local	Quarterly updates provided shared with SSCP	Sefton Council: Communities	Agency progress updates SSCP Agenda /minutes	Quarterly from December 2020 until actions completed	

End DHR Sefton for Publication 20210407