A Domestic Homicide Review concerning the death of Gee Gee (Pseudonym)

(January 2021)

Author: Julie Mackay

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A tribute to Gee Gee from her husband.

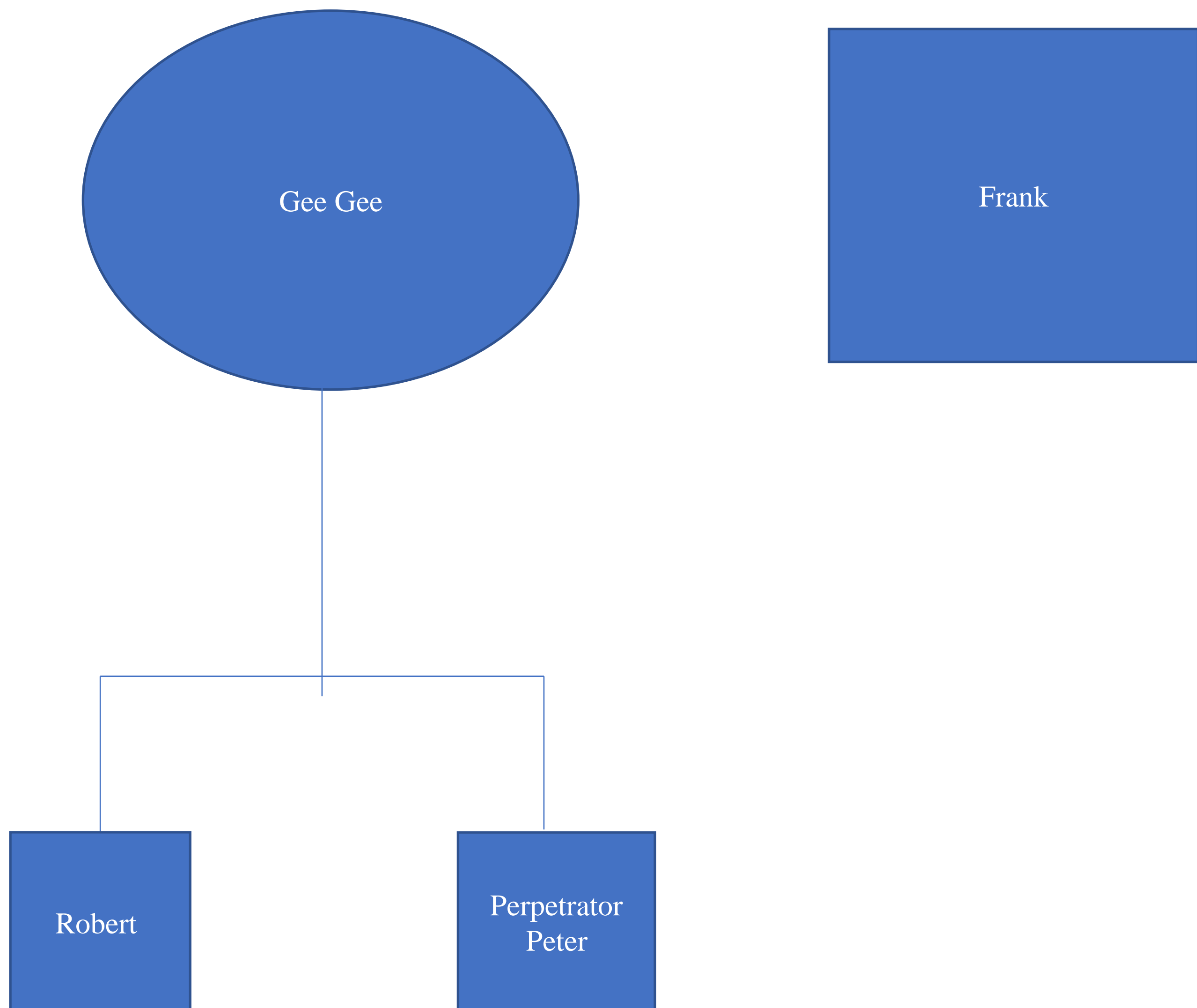
"Gee Gee was a loving mother, grandmother great grandmother and wife who will be sadly missed by all her family and friends.

Gee Gee was a truly caring person who had spent a lot of her working life in the care sector. This overflowed into her interactions with everyone she encountered. She would be engaged in conversation and know all their history within minutes of meeting someone new.

After her mum died who she cared for, she took on a new role as a volunteer. An example of her kindness and thoughtfulness was when she was found hands in the sink washing all the dominoes (and this is pre pandemic) at a day centre. When a member of staff asked what she was doing she responded, “Well I’m sure these lovely people don’t want to be playing with sticky dirty dominoes, it’s the least I can do to make them clean, so they feel nice” No-one else had considered this small touch which had such a huge impact.

Through her kindness and warmth to others she received the same in return and we were lucky to have been on the receiving end, she loved all her family without exception and despite these tragic circumstances they all loved her too."

Genogram



The members of this review panel offer their sincere condolences to the family of Gee Gee for the sad loss of a mother, a grandmother and a wife in such tragic circumstances.

1. Introduction

1.1 This report of a domestic homicide review examines agency responses and support given to Gee Gee, a resident of Herefordshire, prior to the point of her death in January 2021.In addition to the 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 view the report seeks to identify appropriate solutions to make the future safer.

1.2 The victim, Gee Gee was a lady in her 80's who resided at home with her husband, and two adult sons. In January 2021 Gee Gee was at home when the perpetrator, one of her adult sons, struck her with a heavy object, causing a fatal head injury.

2. Timescales

2.1 The review will consider agencies contact or involvement from the 1st January 2020 until Gee Gee's death in January 2021. In addition, agencies were asked to provide an account of any significant events and safeguarding issues outside of the scoping period where this would add value and learning to the review. Disclosure by family members and friends identified some key time points in 2019 so these are included.

2.2 West Mercia Police notified Herefordshire Community Safety Partnership (HCSP) of the death of Gee Gee on 4th February 2021. The Joint Case Review Group (JCR) on behalf of HCSP reviewed all the circumstances of this case against the criteria set out in Government guidance and recommended to the Community Safety Partnership Chair that a Domestic Homicide Review (DHR) should be undertaken.

2.3 The process began with an initial scoping exercise as part of the rapid review commissioned by the Community Safety Partnership which was prior to the first panel meeting. The aim was to identify agencies that had any involvement with the victim Gee Gee, the perpetrator Peter and in a broader sense with the other family members, giving due consideration to disclosure and confidentiality.

2.4 The Home Office was notified of the intention to conduct a DHR on 15th April 2021.An Independent Author for the DHR was appointed. Prior to the first panel meeting a rapid review was carried out by key partners to identify any immediate learning and inform the terms of reference. The terms of reference were drafted at the first panel meeting.

2.5 The first panel meeting was held on the 17th July 2021. The panel met on two further occasions in September 2021 and December 2021. The report was completed in May 2022. During the review period there were on going court proceedings which concluded with the conviction of the perpetrator for Manslaughter.

2.6 The findings of each review are confidential. Information is available only to participating officers and professionals and their line managers. To ensure the anonymity of the victim the pseudonym of Gee Gee was chosen by her husband. To further protect the family, pseudonyms were also chosen for the victim's husband, her eldest son and her youngest son, the perpetrator. These names were chosen by the independent chair and in consultation with the victim's husband to ensure none of the names had any family connection.

2.7 Gee Gee was a white British female, aged in her 80's at the time of her death. The perpetrator, her son "Peter", is a white British male aged in his 50's at the time of her death.

3. Terms of Reference

3.1 Appendix A

4. Methodology

4.1 The domestic violence, Crimes and Victims Act 2004, establishes at section 9(3), [1]a statutory basis for a review, which was implemented with due guidance on 13th April 2011 and reviewed in December 2016. Under this section a domestic homicide review means a review of the circumstances in which the death of a person aged 16 years or over has, or appears to have resulted from violence, abuse or neglect by A person to whom he was related or with whom he was or had been in an intimate relationship.
A member of the same household as himself, held with a view to identifying the lessons to be learnt from the death.

4.2 Where the definition set out in this paragraph has been met, then a review must be undertaken.

4.3 It should be noted that an intimate personal relationship includes relationships between adults who are or have been intimate partners or family members, regardless of gender or sexuality.

4.4 In April 2021 the government introduced a new domestic abuse bill[2] which provides cross-government definition of domestic violence and abuse. This is designed to ensure a common approach to tackling domestic violence and abuse by different agencies. The new definition states that domestic abuse and violence is

Behaviour of a person towards another person is "domestic abuse" if:

- They are each aged 16 or over and are personally connected to each other, and the behaviour is abusive.

Behaviour is "abusive" if it consists of any of the following:

- Physical or sexual abuse
- Violent or threatening behaviour
- Controlling or coercive behaviour
- Economic abuse
- Psychological, emotional or other abuse

4.5 It does not matter whether the behaviour consists of a single incident or a course of conduct.

[1] https://www.gov.uk/government/publications/revised-statutory-guidance-for-the-conduct-of-domestic-homicide-reviews

[2] https://www.legislation.gov.uk/ukpga/2021/17/contents/enacted

4.6 “Economic abuse” means any behaviour that has a substantial adverse effect on their ability to Acquire, use or maintain money or other property, or Obtain goods or services.

4.7 A child who witnesses domestic abuse is considered a victim under the Domestic Abuse Bill.

4.8 This review is not an inquiry into how Gee Gee died or who is to blame. These are matters for the Coroners Court and the Criminal Courts. Neither are they part of any disciplinary process. The purpose of the DHR is to:

I. Establish what lessons are to be learnt from the homicide regarding the way in which local professionals and organisations work individually and together to safeguard Gee Gee.
II. Identify what those lessons are both within and between the agencies, how and within what timescales they will be acted upon and what is expected to change as a result.
III. Apply these lessons to service responses including changes to the policies and procedures as appropriate.
IV. Prevent domestic homicide and improve service responses for all victims and their children through improved intra and inter agency working.
V. Contribute to a better understanding of the nature of domestic violence and abuse and to highlight good practice.[3]

5. **Involvement of Family and Friends**

5.1 The victim’s husband, Frank (pseudonym) made a significant contribution to the review. He was supported by an advocate from victim support. The Chair met with Frank, and he attended a panel meeting. The terms of reference were shared with Frank, and he had an opportunity to make any amendments.

5.2 The draft report was shared with Frank and his comments and amendments were taken into consideration. He had the opportunity to discuss the report with the Chair and was provided with a copy which he could read in his own time. He was updated throughout by the advocate.

5.3 The older son, Robert (pseudonym), was contacted by letter and through the victim support advocate. He did not wish to engage with the process. He was updated by the advocate and consideration was given to his support as he had been displaced following the death of Gee Gee.

5.4 The Chair also met with a friend of the perpetrator and a family friend, both of whom provided valuable insight.

5.5 Contact was made with the perpetrator through the secure hospital where he was detained offering him the opportunity to engage in the process. He did not respond.

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

6. **The Review Panel Members**

6.1 In accordance with the statutory guidance, a panel was established to oversee the process of the review. Ms Mackay chaired the panel and also attended as the author of the Overview Report. Other members of the panel and their professional responsibilities were as listed below. The panel members all expressed a desire to remain anonymous, their identities were known by the Chair, and they did introduce themselves when the family attended a panel meeting.

Name	**Designation**
Herefordshire and Worcestershire CCG	Associate Director for Nursing and Quality/Designated Nurse for Safeguarding Adults and Children NHS Herefordshire and Worcestershire CCG
Herefordshire Council – Adult Social Care	Assistant Director, ASC Operations
Herefordshire Public Health	Public Health Specialist
West Mercia Police	Detective Inspector
Wye Valley NHS Trust	Adult Safeguarding; Advanced Practitioner
Herefordshire and Worcestershire CCG	Deputy Designated Nurse Safeguarding Nurse
Herefordshire and Worcestershire Health & Care NHS Trust	Safeguarding Services Manager
West Mercia Women's Aid	Herefordshire County Manager
Julie Mackay	Independent Author

7. **Author of the Overview Report**

7.1 Home Office Guidance requires that:

> "*The Review panel should appoint an Independent Chair of the Panel who is responsible for managing and co-ordinating the review process and for producing the final Overview Report based on IMRs and any other evidence the Review Panel decided is relevant, and …The Review Panel chair should, where possible, be an experienced individual who is not directly associated with and of the agencies involved in the review"*

7.2 The Independent Author, Ms Julie Mackay was appointed at an early stage to carry out this function. She is a former Senior Detective in Gloucestershire Police, having headed up the Major Crime Team (homicide investigations) for three police forces in the South-West. Since retiring she has been employed by Her Honour Judge Munro, Coroner for the Inquests into the deaths of four victims of serial killer Stephen Port, providing an overview report on the Police investigations. Prior to this review process she had not had any involvement either directly or indirectly with the delivery or management of services within the agencies involved or family members concerned She has attended

the meetings of the panel and members have contributed to the process in preparation of the report and helpfully commented upon it.

8. Parallel Proceedings

8.1 The panel were aware that the following parallel proceedings were being undertaken. The Independent Author notified HM Coroner on the 3rd June 2021 that a DHR was being undertaken.

8.2 A criminal investigation commenced on the date of the incident in January 2021. The perpetrator was subsequently convicted of manslaughter on the grounds of diminished responsibility and a hospital order for his detention was made by the court.

9. Equality and Diversity

9.1 All parties involved in this case are white British, the identified protected characteristics are age and disability (mental health). Gender (sex) has also been considered in the context of male victims of domestic abuse being recognised and the relevant support policies and processes being present. The other characteristics under the equality Act 2010 that were considered are gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, and sexual orientation.

10. Chronology

10.1 This review concerns Gee Gee, aged in her 80's who was married to Frank for 34 years. Gee Gee had two sons from a previous marriage. Robert was the eldest, Peter was nine years younger and the perpetrator in this case. Both sons had returned home to live with Gee Gee and Frank some 20 years earlier following the respective breakdowns of their own marriages and had remained there throughout. Gee Gee was a very caring and engaging person who wanted to do the best she could for her family. This included not asking either son to leave or move out even when relations in the house became strained.

10.2 Gee Gee's first marriage was abusive, and she made a decision to leave her husband when Robert had already left home. At that time, it was not possible to take Peter with her immediately and he remained with his father for a period of months until Gee Gee had accommodation and was able to support him.

10.3 Gee Gee and Frank met and were subsequently married in 1986. They lived at different locations and eventually settled in Herefordshire. Gee Gee was an active person and she worked in the care sector up until her retirement. Even after retirement she continued to volunteer. She is described by family and friends as a person who loved people. She would very quickly engage with anyone she met and know all about them, often becoming friends in a short space of time.

10.4 Robert had been established in the community and had an income through independent work. He is described by family members and friends as consuming large amounts of alcohol which would then have an adverse impact upon his mood. He could become both verbally and physically aggressive towards the other family members. He is also described as "seeing" famous people, indicating a mental health issue, although none was diagnosed. It is understood he had three sessions with a mental health

provider prior to lockdown in March 2020 and then disengaged as he did not consider that he required the support. Agencies have not supplied any data regarding Robert as he has not engaged in this process or provided the necessary consent.

10.5 Peter had his own properties and worked at a local factory until approximately 2018. There were some challenges at work where it is described that he has been bullied by other staff members. This went on for some time and eventually led to a mental health breakdown and he ceased work.

10.6 The relationship between the two brothers whilst living at the home address is described as strained. Robert prepared his own food and ate separately to the rest of the family. Peter would leave the room when Robert entered. Gee Gee wanted them both to be able to live there in harmony. Peter felt aggrieved that she, Gee Gee, did not challenge the behaviour of Robert.

10.7 Robert and Peter had an altercation at the end of October/early November 2019.During this incident Robert was cooking in the kitchen when Peter walked in and Robert stated that he was going to stab Peter. This was followed by a falling out over tobacco, which resulted in Peter leaving the address in the middle of the night and going to live with a friend who was renting one of his properties. He refused to engage at all with his mother, Gee Gee, and communication was for some time through the friend and Frank. This incident was not reported to the Police or any other professional at the time.

10.8 In December 2019, the perpetrator, Peter, due to his mental health, felt unable to cope any further and was asking for help. Frank took him to the accident and Emergency department (A&E) at Hereford hospital. The Crisis and Home Treatment Team (CAHTT) were contacted by A & E. During a telephone discussion, it was deemed that Peter did not meet the criteria for urgent assessment. A & E staff were advised to consider a short diazepam prescription to help Peter overnight and that he should be signposted to his GP. None of this information was shared with Frank, by either staff, even on a redacted basis, or by Peter.

10.9 In February 2020 Peter considered moving back into the family home, but by March had decided not to do so and remained with his friend. On the 23rd of March 2020 the first national lockdown was imposed in England as the Coronavirus took hold across the UK. He had been receiving support from his GP and was offered further treatment, but he declined the intervention of counselling.

10.10 Gee Gee was herself in poor health and undergoing tests for dementia which in turn identified a heart problem. Even though Covid had impacted upon access to services and the method of access, Gee Gee maintained contact with her GP surgery and received the necessary referrals to help with her health.

10.11 All agencies had two weeks' notice to adapt their ways of working. This included moving away from face-to-face appointments and utilising technology for online, telephone and video calling to assist in management of appointments and service delivery. There was an impact upon face-to-face access and some outpatient and routine appointments. These factors have been considered as part of this review.[4]

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[4] COVID-19 policy tracker 2020 (health.org.uk)

10.12 In February 2020 Gee Gee disclosed to her GP there were problems at home with her sons (even though Peter was not actually residing at the address) and the different challenges that each were dealing with. Whilst supportive, it was necessary for the individuals (i.e. her sons) to seek help and support as they were adults and third-party reporting did not enable access to the relevant service.

10.13 Throughout 2020 the mental health of Peter continued to be a personal challenge for which he sought and received support. He secured telephone counselling but there was no visual contact thus preventing the counsellor from seeing how he actually presented. The behaviour of Robert remained erratic and the tension in the house was palpable, particularly given the national situation with lockdown and restricted movement, according to family members.

10.14 In the week leading up to the death of Gee Gee in January 2021 the mental health of Peter was noticeably deteriorating. He is described by family, as not leaving his room, wearing only his underwear, stating that he needed help and two days before getting into bed with Gee Gee and curling up in a foetal position, crying. These symptoms were discussed with a close friend, but not with agencies who could have provided help and support. Frank believes that the decision not to seek help goes back to historic requests (20 years earlier) by Gee Gee in respect of Robert when none was forthcoming.

10.15 On the night before her death Gee Gee contacted the GP surgery. She described physical symptoms being displayed by Peter: including high temperatures, racing heart and anxiety. The GP advised that they arrange for an ECG the following day. The focus was on the physical symptoms as these were what were described to the GP that day by Peter himself and Gee Gee. Gee Gee was advised that if his condition deteriorated any further, he could be taken to A&E.

10.16 The following morning, which was the day of her death, Gee Gee again contacted her GP. She explained the situation in respect of Peter's mental health which had continued to deteriorate overnight. The surgery immediately arranged for the mental health service to make contact, which they did. It was arranged for Peter to attend for an assessment that afternoon. The delay in attendance was to enable Gee Gee to attend her own medical appointment earlier that afternoon and was at her request.

10.17 Just after midday on that day in January 2021 Robert, Peter and Gee Gee were all in the garden when Peter caused a catastrophic injury to Gee Gee. Frank was out shopping at the time and returned shortly after the assault to be told by Robert that Peter had killed her. They both remained and awaited the arrival of the emergency services.

10.18 Peter is currently detained in a secure mental health unit, having been sentenced to a hospital order following his conviction for manslaughter on the grounds of diminished responsibility. Frank has remained at the family home and Robert is now in independent accommodation. The care of adults at risk management (CARM) protocol has been followed in respect of Robert since Gee-Gee's death and his move to his own accommodation. This process ensures that appropriate services and support are provided to Robert.

11. Overview

11.1 The presence of physical violence in the family home was first disclosed to police in around 2007 (outside the time parameters of this review and not involving the perpetrator or victim). There was a reluctance for any criminal proceedings to be taken. There was no further direct contact with Police as no-one in the family wanted to criminalise behaviour or considered that the police were the best agency to deal with the problems.

11.2 The next disclosure of any physical violence was made by Gee Gee who referred to an incident when attending the memory assessment service in October 2019. She disclosed that Robert had mental health issues, was alcohol dependent and physically violent to his brother. Gee Gee also disclosed that she had been pushed. This wasn't identified as an assault but was recognised as a safeguarding concern and without knowing the full disclosure it is possible that this took place when she was trying to intervene between the two brothers as has been indicated by other family and friends.

11.3 Consideration was given at whether a safeguarding concern should be raised with the local authority. Gee Gee herself did not consent to this as she was concerned it would increase the risk at home. [5]

11.4 Discussion took place with the mental health care provider at the time and the Local Authority Safeguarding Team who confirmed that Gee Gee would need to consent to a safeguarding concern being raised. Under the Care Act 2014 there are certain circumstances whereby if consent is not provided but if the risk is significant or there is considered that there is a risk to others, then a safeguarding concern can be raised with the local authority.[6]

11.5 The risk was not considered to be high. Gee Gee did consent to a referral to the police being made so that a marker could be placed upon the address, a Gazateer alert. Gee Gee's husband was aware of this referral. This would inform police should they be called to the address of previous incidents that had been disclosed to other agencies. If this referral had gone through and been received, then a crime would also have been raised in line with home office crime recording standards.[7] The notification was not ever received by the Police.

11.6 Gee Gee also disclosed that Robert had been seen by a GP who was referring him for mental health support. Whilst integral to this review, Robert is neither a perpetrator nor victim and has not engaged with the process so details of his engagement with any agencies is not known outside of family and friends' disclosure.

11.7 Peter had been suffering mental health problems for a number of years following bullying incidents at his work. He felt unable to continue going to work as a result of this

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[5] This adhered to the six principles of the Care Act 2014 & Herefordshire CCG safeguarding policy https://herefordshiresafeguardingboards.org.uk/herefordshire-safeguarding-adults-board/for- professionals/

[6] Care Act 2014 https://www.legislation.gov.uk/ukpga/2014/23/contents/enacted

[7] Home Office Counting Rules for Crime https://www.gov.uk/government/publications/counting-rules-for-recorded-crime

and left in around 2018. He had not worked since. Whilst this incident and associated engagement with support agencies is outside the terms of reference it is important to understand the point at which his mental health visibly deteriorated.

11.8 An inference could also be drawn that Peter suffered from adverse childhood experiences (ACE's). As a child he lived in a home where his father was abusive towards his mother as well as him and his brother. The impact of his mother leaving him with his father, whilst she established a secure home that they could then live in, may have had a lasting effect. His exact age at that time has not been established, but it is believed he was approximately 14 years old. In the 1980's there was no recognition of ACE's but the long-term impact should be highlighted through lessons learnt in this review.[8]

11.9 On 4th December 2019 Peter attended at A&E in Hereford. His mental health had deteriorated significantly at home, he is described as requesting help, being unable to cope and feeling very anxious. His friend took him to A&E with his stepfather Frank. Peter was assessed as not having any suicidal thoughts and no thoughts of harming himself or others so did not meet the criteria to be assessed by CAHTT. Staff at A&E took verbal advice from them over the phone which was that he should see his GP the next morning. Peter's friend agreed to look after him overnight and take him to see his GP in the morning. It is unclear as to why this plan was not communicated to his stepfather and he, Frank, was left feeling unsupported and considers the impact was such that he did not consider A&E as an option in the future.

11.10 When being assessed by staff at A&E Peter disclosed that he had been on anti-depressants but not taking them regularly. He told staff that he used to live with his Mum and Stepdad and brother, who was physically abusive and had some sort of psychiatric problem. He also disclosed that his mother did not want to inform anyone about the problems with his brother.

11.11 The staff discussed with him safeguarding or police intervention in relation to the disclosure about his brother. At this time Peter refused to consent for any referrals to be made. It is unclear if he was identified as a victim of domestic abuse with his brother as a perpetrator.

11.12 From January to March 2020 Peter remained away from the family home but the relationship with Gee Gee was starting to be re-built. He still blamed her for abandoning him as a child and for choosing Robert over him. Gee Gee felt that she couldn't ask Robert to leave as she was fearful that he would not be able to survive or that he would take his own life if he was on his own. She did not discuss these fears with any agency.

11.13 Peter had started to engage with support services. In February 2020 he had a face-to-face appointment with the Community Psychiatric Nurse. His medication was discussed and suggestions around some positive aspects were recognised, and the negative aspect was addressed through a recommendation for a GP review to consider a reduction in medication. Peter declined a referral to psychological therapy. Then lockdown in March 2020 was introduced. Peter's engagement stopped and he stated he

[8] Adverse Childhood experienceshttps://www.cdc.gov/violenceprevention/aces/index.html

didn't want to return home so remained at the friend's house until May 2020 when restrictions began to ease.

11.14 When Covid restrictions had been eased Peter engaged with a commissioned counselling service. He had a total of 16 sessions, which included 8 with a private provider, between February 2020 and January 2021. Peter appeared to enjoy engaging with the counsellor, but the actual tangible effects were limited as he disclosed increased anxiety due to the situation at home in September 2020 and again in December 2020. There is a comment that a change of medication had assisted in some improvement, but it took some time to achieve this.

11.15 The therapist from the counselling service submitted a safeguarding referral on the 3rd September 2020 to adult social care. It highlighted Gee Gee as the person who was at risk of domestic abuse. This was following disclosure from Peter that his brother had recently threatened to kill him and described a long-term picture of alcohol consumption, bullying and controlling behaviour by his brother towards the family. Peter was not identified as an adult with care and support needs at this time but did meet the criteria. This referral was compliant with the policy for referral to adult social care.

11.16 Peter was not identified as a victim of domestic abuse. Therefore, discussions regarding appropriate signposting or referrals for him as a victim of domestic abuse were not considered or made to services providing support to victims of domestic abuse. There is no evidence that this was gender based, but it is important to highlight the impact of domestic abuse on male victims and that they should be recognised as such.

11.17 The therapist did also speak with Gee Gee on the telephone, but her response was described as guarded. Peter had stated she did not want police involvement or his brother to be evicted. It is understood that she did not feel she could speak freely on the telephone in her home as there was no privacy and both sons were a constant presence, especially during covid when all were living in the same home.

11.18 Social care did contact Gee Gee approximately 10 days later. Gee Gee stated that things had been fraught, but she considered the risk had subsided, she advised the social worker that she had a background in care, thus implying that she was aware of the different levels of risk. Gee Gee also informed them that the mental health of Peter was improving with the counselling support. She denied any physical assaults and the subsequent assessment concluded that she did not meet the criteria for a Section 42 Enquiry.[9]

11.19 The GP records disclosure from both Gee Gee and Peter regarding the situation at home. It is recorded as sibling rivalry and was recorded on four occasions between December 2019 and January 2021.Peter did raise with his GP frustration that Gee Gee would not ask for help from the Police. No referral was conducted by the GP at that stage. This was an opportunity for the GP to ask either supplementary questions of Gee Gee or to seek a review of all family members currently residing at the house. Older patients are often reluctant to disclose abuse that is taking place within the home, or do not consider it to be abuse. This approach results in services who would be able to provide support not being alerted or engaged. Those services are not necessarily the

[9] Section 42 Care Act 2014 https://www.legislation.gov.uk/ukpga/2014/23/section/42/enacted

Police. If this had been conveyed to Gee Gee she may have provided more comprehensive disclosure.

11.20 Between 29th October 2020 and 5th January 2021 Gee Gee commenced eight sessions of the heart programme with a cardiology clinical nurse specialist,via telephone appointments. During these sessions she did not disclose any concerns or abuse other than on week five “managing stress” she said she was supporting her sons mentally but did not wish to expand further. In a letter at the conclusion of the programme from cardiologist to GP it is noted that Gee Gee suffers heart palpitations due to a high stress environment at home. Due to Covid all discussions took place over the telephone when normally they would have been face to face. It was felt by the nursing specialist that someone else may have been present during these conversations, but it is not known who that person was or whether it restricted Gee Gee’s ability to make any disclosure. It is not recorded if the nurse asked safeguarding questions.

11.21 On 2nd November 2020 the second lockdown was introduced in England, Gee Gee’s personal connection with her friends was reduced further as a result of the second lockdown, but she did maintain regular telephone contact with one close friend. Gee Gee described feeling beaten up (emotionally), hanging on by her fingernails and not knowing where to turn. The friend could hear on the phone lots of shouting, banging of doors etc. It was relayed that Robert was consuming more alcohol, his relationship with both stepfather, Frank, and Peter was deteriorating. Peter locked himself in his bedroom for most of the time. Gee Gee would usually go to her room by 7pm to watch TV. These events were not relayed to any professional.

11.22 On 22nd December 2020 the mental health provider, following the initial screening discussion with Peter, contacted Advice and Referral Team to discuss the family situation specifically that Peter stated that Robert made verbal threats of violence which was impacting Peter’s mental health. The Safeguarding Customer Service Officer discussed the call with Senior Practitioner and the Senior Practitioner advised that there was no need to raise a safeguarding concern since key individuals have mental capacity and no claim of care and support (in line with section 42 Care Act 2014). There was no recognition of domestic abuse that was being reported by Peter. This pre-dated CARM, but there was still in place a process for referral for vulnerable adults. The first stage of this process did take place, in that it was discussed with a senior practitioner, however this second tier also failed to identify the issue of domestic abuse.

11.23 The same information is recorded on the notes of Gee Gee, identifying that there was an older couple present in the premises with Robert and Peter. The Senior Practitioner in the Safeguarding Team (adult social care) was consulted. He was advised about the Safeguarding Concern raised in Sept 2020 and that Gee Gee did not want support at that time or feel able to engage. In terms of Peter, the Senior Practitioner said that since Peter had mental capacity and no care and support needs then “he can leave the home if he wants to” but no Safeguarding Concern is required.

11.24 This was a missed opportunity to have a safeguarding meeting in respect of all the adults present in the house to comprehend the individual needs and behaviours and their impact upon others. Adult social care had the opportunity to convene a multi-agency meeting to share all relevant information. There is a process in the GP surgery to conduct an internal review as well as a wider multi agency review. There was a lack of recognition of the “elderly” and the associated vulnerability that is present with an

older person, even if they have mental capacity. Coupled with a lack of recognition regarding Peter's mental health and associated vulnerability and a lack of identification of domestic abuse occurring within the household prevented intervention from services that would have been able to offer support to individuals and the collective family.

11.25 The friend also believed that in the two weeks prior to Gee Gee's death Peter had had another medication change. It is in fact documented that Peter had in fact reduced his medication himself and felt that his condition had improved (18th January 2021)

11.26 During a GP review on the 18th January 2021 Peter stated that he had chosen to reduce his medication by half and that he was feeling much better. It is noted that there had been a reduction in his mental health symptoms and advice was provided on how to contact the mental health provider should he feel the need to engage again.

11.27 There is little recorded interaction with any agency in January 2021. The country had entered a third national lockdown on the 6th January 2021. The mental health of Peter deteriorated in the week commencing the 25th January 2021. This was not raised with any agency until the 28th January 2021, and then it was described as physical symptoms rather than mental health symptoms.

11.28 In January 2021, the exact date is not recorded, primary care mental health services admin note recorded that Peter has a PHQ Score 12/27. PHQ scores of 11-15 are considered to reflect moderate depression, 15-20 moderately severe depression and 20-27 severe depression.[10] General Anxiety Disorder (GAD) score 14/21.GAD scores between 10 and 14/21 are moderate anxiety with 15-21 indicating severe anxiety. "During the assessment identified risk factors regarding your safety and the safety of others around you. You have discussed that calling the police if you or a family member is feeling threatened by the person causing abuse" It is clear from this note that there is ongoing advice around safety.[11]This safety advice demonstrates the recognition that there is abuse and that there is an option of contacting the police. However, it also demonstrates lack of awareness of Peter as a victim of domestic abuse and a missed opportunity as highlighted above around referral to other services that could have provided support.

11.29 Gee Gee did discuss it with her friend on Tuesday 26th January 2021. Gee Gee said it was difficult to talk freely. She described the situation at home where Robert was drinking heavily, there was conflict between him, her husband and Peter. This included a physical altercation with Robert and Frank when Gee Gee had intervened. Peter then grabbed the phone and was described as hysterical, on a complete high, talking loudly and behaving in a volatile manner. It was unusual for him to behave in this manner, and when asked if he was OK, he relied "yes all shite as usual" What are you on (?) "That will be the medication the drugs" he was known to smoke cannabis and the friend believed him to be "off his head" on something (possibly controlled drugs, given an awareness that Peter had used controlled drugs previously).

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[10] Guidance for depression in adults
https://www.nice.org.uk/guidance/cg90

[11] GAD: General Anxiety Disorder Assessment: 10-14 Moderate anxiety
https://adaa.org/sites/default/files/GAD-7_Anxiety-updated_0.pdf

11.30 Peter returned the phone, but the situation then clearly deteriorated further with lots of shouting and doors banging and Gee Gee said she needed to terminate the call, she was very upset and crying. No further contact was made that evening. The friend did not contact any other agency and did not consider it was her position to do so as Gee Gee was not supportive of that course of action. Gee Gee's husband Frank describes over the next 48 hours the mental health of Peter as getting worse. He locked himself in his room in only his underwear. On Wednesday 27th January 2021 he got into bed with Gee Gee. He was very hot, had a high heart rate and was in a foetal position saying he needed help. He described Peter as telling Gee Gee every day that he hated her, and she was responsible for abandoning him as a child and for not evicting Robert, who was very disruptive. This behaviour was not discussed with any agency.

11.31 When there was no improvement on Thursday 28th January 2021 Gee Gee called the GP surgery at approximately 4:10pm. She spoke with a GP and described physical symptoms and also put Peter on the phone. He spoke for about 30 seconds before handing the phone back. The GP advised that they arrange for an Electro- Cardiogram (ECG) the following day and if the situation should deteriorate further then to go to A&E. The symptoms that were being described to the GP were Peter as being slightly anxious, cognition seems OK, and Gee Gee is tearful. The GP did have access to both medical records at the time of the consultation. The main concern that was highlighted was the raised blood pressure of Peter which led to the ECG being arranged for the following day.

11.32 As a family they did not consider A&E to be a viable option for Peter, given the previous experience and their perception that out of hours no mental health trained staff are available. The police were never considered as an option. They didn't recognise that there was a mental health crisis team available at the hospital (which is provided by the health care trust) or through the NHS helpline[12]

11.33 Gee Gee spoke again to her friend on the Thursday evening, Gee Gee described Peter as having gone downhill. She had phoned the GP as he was having, what is described to the friend as a psychotic episode. This is not the terminology used to describe the symptoms to the GP, sweating, burning up heart racing, behaving erratically. She told her friend that she had asked if they could send mental health team out to do an assessment with a view to sectioning him, he needed to be sectioned. Gee Gee's description of the conversation is at odds as to the information received by the GP and recorded at the time. The GP stated that they but would arrange for an ECG the following day and if the condition of Peter deteriorated further, he could be taken to A&E.

11.34 The Thursday night is described as quieter by family. Peter was still clearly very unwell on the Friday. Gee Gee again contacted the surgery and spoke with her own GP. They immediately took steps to contact the mental health team who in turn contacted Gee Gee and Peter. As a result of these discussions, it was agreed to carry out an assessment that afternoon. The reason for the slight delay was to enable Gee Gee to attend a medical appointment she had that afternoon. This is in line with a patient first approach and considered the importance of Gee Gee's medical appointment.

[12] https://www.nhs.uk › advice-for-life-situations-and-events

11.35 Just after midday on Friday 29th January 2021, Peter fatally injured Gee Gee. At that time the only other person present was Robert as her husband, Frank, had left to get the weekly shop. Peter had never been physically violent to anyone previously.

12. Views of the family

12.1 Gee Gees husband and granddaughter agreed to take part in the DHR process. Her husband attended one of the early panel sessions, providing an impactful picture of what life was like. In addition, a letter was sent to each of her son's, but neither wished to participate.

12.2 Gee Gee's husband, Frank, stated that they were a very private family and neither he nor Gee Gee would have considered sharing any of their problems with even closest family members. Since her death he has recognised the importance of being able to talk openly about the challenges he faced then and now and has been very engaging in the whole process.

12.3 Frank has described that he has been a part of the family for 37 years and whilst not the natural father of Gee Gee's two sons he was a stepfather who cared for them and was an integral part of their adult lives. Frank described the challenges he faced as a stepfather, not being able to intervene when he wanted as Gee Gee did not share the same view. An example of this would be either more engagement with agencies or even the removal of the eldest son from the family home.

12.4 Frank stated that his relationship with the eldest son, Robert, was troubled. He found it difficult to manage the mental health and alcohol challenges that were presented and the behaviours of Robert in the form of outbursts verbal aggression and, on occasions, physical aggression. Frank found himself retaliating by shouting back or having to walk away, leaving the behaviour unchallenged, because Gee Gee wanted peace in the household and didn't feel that confrontation assisted.

12.5 In respect of his relationship with Peter, the perpetrator, Frank found this less confrontational but still difficult to manage on a personal level as he witnessed first-hand the emotional pain caused to Gee Gee, when on an almost daily basis Peter told her that he didn't like her and accused her of favouring Robert over him.

12.6 Notwithstanding this when Peter required help in December 2019 it was Frank who went to take him to A&E and acted as a mediator between Peter and Gee Gee over the next few months which eventually facilitated his return home.

12.7 Frank felt that this engagement at the hospital left them as a family feeling unsupported. He was unaware that there had in fact been engagement with the mental health team and was left with an impression that no-one was available to help at A&E out of hours with mental health problems. This impacted on the decision making in January 2021 when the option of A&E was given by the GP if the condition of Peter deteriorated any further during the evening

12.8 Frank was unaware of the ability to contact the mental health crisis team or the Police out of hours or the support that they could provide.

12.9 Frank did not see himself as a victim of domestic abuse when Robert had assaulted him or been verbally abusive. He attributed the behaviours to being associated with mental health or alcohol issues. He did not consider reaching out to an independent agency for support or his GP. Many years earlier (outside of the scoping period by over ten years) Frank had contacted the Police when he was assaulted by Robert but was left with an impression that not much could be done, this was coupled with Gee Gee not wanting to criminalise her son. He therefore did not consider the Police as an option.

12.10 Frank was aware, Peter, was receiving counselling via telephone and that this appeared to help. He does have a view however that these sessions would have been better via a video call so that the counsellor could see how Peter was presenting in a visual manner as well as audible. Frank felt that Peter presented in a more positive manner on the telephone than perhaps he was feeling on occasions.

12.11 Being integral to this review has enabled Frank to reflect upon the services available and his own engagement and whilst he comprehends the choice's he made at the time sharing his experiences with the panel has assisted in his journey. Equally importantly, it helped the panels comprehension of the circumstances at home balanced with the knowledge had by agencies at the time highlighting a gap between the two.

13. **Analysis**

13.1 A representative from West Mercia Women's Aid was invited to the panel meetings. They provided detail around the services that are available to victims of domestic abuse and confirmed that this support is also available to men. It was raised that the name "Women's Aid "could either deter men or perhaps make them feel that the service wasn't open to them. The highest number of domestic abuse victims remain women and as such services are aimed to tackle Violence Against Women and Girls. However, WMWA are committed to making their services accessible to all victims of Domestic Abuse and as such they have safe accommodation provision, IDVA support and access to the Domestic Abuse Helpline specific to male survivors.

13.2 The representative also provided some context around the level of abuse being described in the home as unlikely to be considered high on any DASH risk assessment. This would not have been the case if the threats to kill/ knife incident had been disclosed by Gee Gee. This level of violence would provide access to additional support that was either necessary or available and this could include a referral to an IDVA (Independent Domestic Violence Advisor). There is Community based group support and a 24hr Helpline for low-medium risk cases which would have been accessible for the family if a referral had been made.

13.3 There is an organisation which can provide advice and support to male victims as well as female victims of Domestic Abuse in Herefordshire and Worcestershire. The organisation has considered and responded to differing needs of the community, including providing support for any person regardless of age, gender, race and sexuality.

13.4 During this period Gee Gee did have five face-to-face appointments with medical professionals, the remainder were via the telephone. She did disclose additional stress at home caused by her son's behaviours on two occasions but was reluctant to provide further detail. These disclosures were made over the telephone, and it was not clear that

she was able to speak freely. Her husband has subsequently confirmed that she could not speak without being overheard.

13.5 As part of the ongoing training to professionals the challenges individuals may have regarding open conversations should be automatically considered and if there is concern that they are unable to speak freely either on the telephone or in the presence of another third-party efforts should be made to create opportunities for confidential conversations. Probing or supplementary questions should be asked as it is not unusual for older people to either minimise or fail to disclose the abuse that is occurring. This has been highlighted in previous Domestic Homicide Reviews.

13.6 The safe live survey identified that service providers are not used to recognising and responding to familial domestic abuse involving older people and adult children. There is little training focussing upon child parent abuse which can lead to a lack of confidence in supporting individuals who may not be forthcoming or feel able to disclose the true extent of their situation.

13.7 The Accident and Emergency Department when reviewing the perpetrator in December 2019 did in fact consult with the mental health teams and this was conveyed to the patient. However, it left the other family members who did not have this knowledge feeling that the level of service was not as it could or should have been and influenced their decision making in January 2021. It is recognised that the primary responsibility is towards the patient and that there are confidentiality issues that must be managed and so whilst it would not have been appropriate to discuss any care plan, confirmation that appropriate experts had been consulted may have provided reassurance and confidence in the service.

13.8 There was no recognition that Peter was a victim of domestic abuse when he disclosed that his brother was physically abusive towards him. There was appropriate information sharing with partner agencies. When he presented in A&E he refused a safeguarding referral and had capacity to refuse this. Relevant advice regarding his personal safety was given. However, he was not offered signposting to other domestic abuse services, missing an opportunity to provide support and to gain a broader understanding of the situation in the home environment.

13.9 Strategically the Wye Valley NHS Trust does not currently have an identified individual as the domestic abuse lead. This has been recognised as an essential role by the Executive lead for Safeguarding and the Clinical Commissioning Group and it is currently highlighted on the corporate risk register. There are identified safeguarding nurses within the trust.

13.10 Domestic abuse does not fall within the mandatory training requirements at the Wye Valley NHS Trust. Nicole Jacobs, Designate Domestic Abuse Commissioner for England and Wales states in the pathfinder toolkit “Health settings are trusted environments, used by everyone. Because of this, they are places we can reach those from every background and walk of life subjected to domestic abuse, especially those who may not feel confident seeking help from other professionals. That is why it is critical to ensure awareness about domestic abuse is embedded into the safeguarding policy and practices of all health settings”. This highlights the importance of delivering training.

13.11 There is a hospital IDVA who is available to provide advice and support to both patients and staff. The IDVA and WVNHST Adult Safeguarding Team liaise on a regular basis and staff can also make referrals to the IDVA service or out of hours can contact Women's Aid. The GP surgery have been recognised by the family as providing the most support and the go to agency for all their challenges both physical health and mental health. Gee Gee had frequent contact with her local practice and had disclosed the tensions that were present in the household. These tensions were identified as sibling rivalry and the presence of physical assaults were not disclosed. There was adequate care and relevant referrals for Gee Gee in respect of both her mental health and her physical health. Throughout the pandemic she still had the necessary access to the GP services, and this included face to face appointments as well as telephone.

13.12 There is a facility within the practice to link family members, specifically where there are children in the household, however this is used less often in households of adults. It is recognised that if there is known conflict within a household there are benefits for holding a safeguarding meeting regardless of age.

13.13 There is a facility to use EMIS flagging system for vulnerable adults (adults with care and support needs) when recognised as such. Gee Gee was not identified as a vulnerable adult as she was not an adult with support and care needs, had mental capacity and was independent. In addition, it was not considered that she was a victim of domestic abuse thus not fitting the traditional definition.

13.14 The disclosure that Gee Gee made to the GP practice on the afternoon of the 28th January 2021 did not reflect the disclosure she made to a friend that evening when describing the mental health of the perpetrator. The assessment of the GP was based upon the physical signs that were being displayed.

13.15 Gee Gee was provided with advice regarding deterioration of the perpetrators mental health which included attendance at A&E and contacting the mental health crisis team. Her husband, Frank, was aware of this advice but states neither he nor Gee Gee comprehended that the crisis team were available out of hours.

13.16 The assessment that was done following a call to the GP on the morning of the 29th January 2021 was proportionate and appropriate. It recognised the deterioration in the mental health of the perpetrator and immediately took steps to engage the mental health team. They in turn concluded that additional support was necessary and by arranging attendance at HWHCT clinic that afternoon took into consideration the other medical appointment that Gee Gee had as well as the risk posed by the perpetrator. He had no history of violence towards any family member.

13.17 The practice has a safeguarding policy, and all staff undergo safeguarding training at the appropriate level for their roles as per the Adult safeguarding roles and competencies for healthcare staff 2018.

13.18 The DASH is included in the Herefordshire domestic abuse pathway (2020) but in this case there was no information (disclosure) to instigate its use by the GP practice in respect of Gee Gee.

13.19 Domestic abuse information sharing protocols do exist with other agencies, however in the absence of specific disclosure by Gee Gee no information was shared.

13.20 Safeguarding Adults team received a referral from the memory assessment service when Gee Gee disclosed during a consultation that she was having issues with her adult son: specifically mental health, alcohol dependency and violence towards his brother, who was also resident in the family home. There was a missed opportunity here to comprehend the family dynamics and whether further support was required.

13.21 The safe lives research identified that adult familial abuse also presents challenges as “there seems to be a number of adult children who are experiencing some type of mental health issue including problematic alcohol and/or substance use, however, unless they are a risk to the community, services are not likely to intervene”. This was the case for one of the older victim Domestic Homicide Reviews discussed in Episode 1 of our Spotlights podcast series. On the day leading up to the murder in 2014, both mother (victim) and son (perpetrator who suffered from significant mental health issues) were asking for [the adult son] to go into care and that wasn’t forthcoming. The urgency of that need was not recognised at the time. It was put down to their “volatile relationship”, so domestic abuse hadn’t been looked at in that context. This suggests that services need to have more awareness of domestic abuse in relation to the adult child and parent dynamic, as older people are experiencing further invisibility within this form of abuse.

13.22 Reference by professionals following disclosure by Gee Gee was recorded as sibling rivalry or tensions at home. There is a lack of recognition of the risk factors that contribute to child parent abuse due to little training and awareness sessions.

13.23 In line with the previous health providers safeguarding adult’s policy and the Care Act 2014 advice was sought. Gee Gee did not consent to raising a safeguarding concern with the local authority and did not fit the criteria for an automatic referral under the care act. However, it was agreed that a referral could be done to the police for an awareness marker (a Gazetteer marker) to be placed on the address notwithstanding it was not actually placed.

13.24 Agencies have, because of this review, explored why no gazetteer marker was placed on the address. Examination of Police systems reveal that the notification was never received. It is recorded as being sent by the safeguarding team. The only explanation is an administrative error.

13.25 The approach to identify alternatives to a formal referral and still provide safeguarding was a positive one. Even when the individual does not consent to a referral and they fall outside the Care Act, seeking other opportunities to safeguard which are not as intrusive but share information with key partners.

13.26 The safeguarding team did contact Gee Gee and despite her not wishing to engage they had a personal discussion (making safeguarding personal) and were able to make an informed decision based upon that interaction.

13.27 The Adult safeguarding team received a referral from the independent counselling service who were engaging with Peter, following disclosure that he was the victim of bullying, controlling behaviour and he had been assaulted by his brother. He did fulfil the criteria for opening a safeguarding concern as he had mental health issues and, on this occasion, this was not done. They did not identify him as a victim of domestic abuse,

missing another opportunity for referral to other support services and to enable an opportunity to comprehend the family dynamics in more detail by either involving partners in a broader case conference or through information sharing with all partners involved with all the individuals present in the address.

13.28 There are the relevant policies in place and the opportunity to complete a DASH risk assessment and it should be completed as appropriate. This policy was only available from February 2020 and therefore it is unclear if the practitioner was able to have sight of it at the time of the consultation and the disclosure.

13.29 The perpetrator referred to controlling behaviour of his brother and the impact of this on his mental health. It is apparent from other agencies records that whilst the perpetrator did not engage with this service again, he did in fact engage with two other services. This highlights that he was prepared to continue to seek help and that he was able to identify and access that support from both a private provider and a partner agency during the pandemic.

13.30 At the start of the pandemic all face to face appointments were cancelled due to government guidance and recently the guidance is more relaxed and advocating more for visual/face to face appointments where necessary. It has not been possible to establish the availability of face-to-face appointments due to the pandemic, but a recommendation is that where possible there should be a visual appointment, whether in person or via a video call, so that the agency can see how the individual is actually presenting. (This has been raised by the family).

13.31 With regards to the victim Gee Gee, it is apparent that several agencies were aware of the sibling rivalry that was causing stress within the home. It was not identified as domestic abuse, and this is because the level of the abuse was either minimised or not fully disclosed. Additionally, when offers of further help or referrals were made, they were declined by Gee Gee. There were some further support services available such as women's aid and an IDVA but given the level of violence it would unlikely have been recorded as high on a DASH assessment.

13.32 Recognising that the older generation do not easily disclose the full extent of any abuse they may be suffering and that as a mother Gee Gee did not want to cause disruption to her family and had an overriding desire to nurture may have assisted agencies to ask some additional questions. There is of course no guarantee that any more information would have been divulged.[13]

13.33 The 2016 Safe Lives report referred to above further detailed how older victim-survivors are a "hidden group". It found the low numbers of older victim-survivors accessing domestic abuse services meant "professionals tend to believe that domestic abuse does not occur amongst older people". The report highlighted several complex reasons why self-referral rates to domestic abuse services may be lower amongst older women. These included prolonged periods of abuse, care dependencies, lack of awareness of services and generational attitudes encouraging people to remain silent. In addition, the Safe Lives report said the invisibility of this group was exacerbated by

[13] Research into older people and domestic abuse. https://lordslibrary.parliament.uk/domestic-abuse-of-older-people/

age limits (74 years) found in the Crime Survey for England and Wales (CSEW), as well as other surveys and studies, which excluded consideration of older victim-survivors.[14]

13.34 When there are several family members living at the same property taking a more holistic view of the whole unit would assist in identifying the ongoing issues that have been disclosed and then a more informed decision-making process can take place to ensure the necessary referrals and support are put in place.

13.35 Recognising that the perpetrator was a male victim of domestic abuse would have enabled referrals to other support agencies. Throughout this review there has been reference to domestic abuse from the son who was not the perpetrator, Robert, but this behaviour has had an adverse impact upon the perpetrator's mental health. The behaviours displayed seem to be closely linked to other factors such as mental health and alcohol abuse. The new domestic abuse act recognises abuse within the family home that does not necessarily involve intimate partners.

13.36 There has been some analysis of Adult Family Homicides through the Vulnerability Knowledge and Practice Programme[15]. Between March 2020 and March 2021 there were 184 recorded deaths which were domestic homicides. Of these 40 (21.7%) were adult family homicides with the most common relationship to the suspect was a parent. The proportion of homicide victims increased with age (63% were aged over 55 years).

13.37 The national crime survey (2019) identified that in Domestic Homicides involving older people as victims 44% of perpetrators were the child of the victim.

13.38 Key learning from research, including safe lives (2016) Hillbrand et al (1999) [16], Brenans et al (2016)[17] and SAGE has been that three key areas were mental health, a history of domestic abuse and substance misuse. In the case of this review the suspect is recorded as suffering from mental ill health but did not have a diagnosed disorder prior to the homicide. Peter was not known as perpetrator of domestic abuse, but in fact has been identified as a victim. His misuse of any substances is not documented other than reference from a friend regarding cannabis use. However, all three of these contributors were present within the household but not disclosed to any professional in the context of domestic abuse or as a contributory factor to domestic abuse.

13.39 The review of domestic homicides in this period and the impact of the pandemic has identified that there was not a significant increase in homicides. In 53% of adult family cases where the victim or suspect were known to agencies other than police, they were most engaged with mental health services. Sharing this information with those service providers could assist in enhancing their knowledge of the vulnerabilities linking mental health and domestic homicide to help in the future prevention.

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[14] https://safelives.org.uk/sites/default/files/resources/Safe Later Lives - Older people and domestic abuse.pdf

[15] https://cdn.prgloo.com/media/02d412c416154010b5cebaf8f8965030.pdf

[16] https://www.sciencedirect.com/science/article/pii/S1359178997000566

[17] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9827478/

13.40 In this case the mental health provider did receive disclosure of domestic abuse but failed to identify it as such which then impacted on broader information sharing and the support that other services may have provided.

14. Questions specifically considered during the review

14.1 When considering whether Gee Gee's background in health and social care influenced her engagement with agencies: On one occasion Gee Gee referred to comprehending risk based on her previous work, so it can be inferred that this did influence her disclosure. It is apparent that her approach to personal privacy was a greater influence.

14.2 Considering whether there were missed opportunities for support for Gee Gee or the family for onward referral / CARM considerations? The characteristics that needed to be considered in this case were vulnerability through age and vulnerability through mental health. There is evidence that vulnerability through age was considered, and decisions made in relation to care needs and capacity in respect of Gee Gee. There was a missed opportunity to recognise vulnerability in the form of mental health for the perpetrator. CARM was formally established in July 2021, the principles were present prior to this but referred to as VARM (Vulnerable Adults Risk Management). This has been identified in the relevant IMR.

14.3 In considering the impact of son's mental health on Gee Gee and her ability to cope with her sons' behaviour. This is detailed throughout the review. The challenges posed by her sons caused her stress and anxiety which impacted upon her mental health and her physical health. She did not acknowledge an inability to cope but did mention the challenges, albeit in a watered-down version, to agencies. Her lack of confidence to make a full disclosure hindered the opportunity to provide further support.

14.4 The question that was considered regarding would there have been a different response if they were teenage not adult children? In the event of teenage children rather than adults meant that there would have been automatic referrals to child safeguarding, if they were adults with support and care needs then a referral would have been made to adult social care. In the case of adult children residing at home the opportunity for safeguarding referrals and partnership meeting to identify further support was present but as domestic abuse was not identified the subsequent referrals were not made.

14.5 The Coronavirus pandemic did impact on the ability to have face to face appointments. Some agencies adapted to provide video calling as well as telephone contact. Visual contact enables agencies to establish whether the individual can speak freely and in a confidential setting as well as providing an opportunity to see how the individual (patient) is presenting. Available technology for both agency and individuals also impacted upon this form of service delivery. In the case of Gee Gee she maintained all her appointments, albeit in a different format on occasions.

14.6 Overall, in this case there is no evidence that the pandemic impacted upon the ability of agencies to deliver the services that supported the individuals. There were still some face-to-face appointments and service delivery was consistent. The impact of lockdown did appear to create additional pressure within the family home. It did not prevent the perpetrator leaving the home when he felt unable to remain.

14.7 Did agencies consider the family holistically, consider what else is going on in people's lives? There was holistic consideration by the GP and in particular the regular GP. There is a recommendation that when multiple issues within a home environment are identified a safeguarding meeting should be held to provide a more holistic view. This was not considered by other agencies in this review but there is the process to instigate such a meeting if available information supports

14.8 The mental health of the perpetrator only deteriorated in the days leading up to the homicide, this was not conveyed to professionals. He had never displayed any physical violence towards any family member and was not considered to be a risk. There has not been anything identified in this review that changes that position.

14.9 The practitioners were sensitive to the needs of the victim and the perpetrator; they were knowledgeable about potential indicators of domestic violence and abuse and aware of what to do if they had concerns about a victim or perpetrator? They were less aware when it came to considering the perpetrator as a victim of domestic violence. The availability of training varies with agencies which is directly linked to funding. Agencies that do have embedded training programmes show high levels of completion and good understanding around domestic abuse.

14.10 The agencies all have domestic abuse policies, and these have been referenced throughout. The DASH risk assessment is available to use by all agencies and is universally understood. The victim was not subject to a MARAC or any other multi agency forum.

14.11 In this case there were few key points for assessment as there was no history of domestic abuse from the perpetrator. There was domestic abuse within the household, but this was minimised as sibling rivalry by the victim. It was disclosed as domestic abuse by the perpetrator but not identified as such by the agencies except on one occasion.

14.12 The victim did not make any significant disclosure regarding the situation at home, other than sibling rivalry. The agency who identified the potential risk and made a referral to safeguarding adults and the police could have signposted the victim to other support agencies such as Women's Aid. The safeguarding team could also have made this recommendation when conducting the follow up. The victim did state that there was no risk and she didn't want any other agency involvement.

14.13 Was this information recorded and shared, where appropriate? The disclosure Gee Gee made were recorded by all agencies and in an appropriate manner, reflecting the disclosure.

14.14 When considering if procedures were sensitive to the vulnerability of the victim and perpetrator agencies were considerate towards the needs of the victim. As an older person, her vulnerability due to age may have diminished as she was not a looked after person and didn't have specific care needs. It has been identified that the perpetrator should have been a person with care and support needs, given his mental health issues and this led to the opportunity for a referral and further support being missed.

14.15 Were senior managers or other agencies and professionals involved at the appropriate points? There was consultation with senior managers when appropriate, specifically by the safeguarding adults' team.

14.16 Are there lessons to be learned from this case relating to the way in which this agency works to safeguard victims and promote their welfare, or the way it identifies, assesses and manages the risks? Where can practice be improved? Are there implications for ways of working, training, management and supervision, working in partnership with other agencies and resources?

14.17 Did any staff make use of available training? Domestic abuse training is a mandatory part of safeguarding adults training in HWHCT which must be completed on induction and at least 3 yearly after that. There is over 90% compliance with this across the Trust. CCG also commission a DA training package which is opened to Primary care and Provider health agencies-also encompass multi-agency conference every year for past 3 years.

14.18 The only service that underwent any restructuring was that of the mental health provider and there is no indication that this had an adverse impact.

14.19 All services were available to the victim, the primary service was that of her GP, other specialist medical services also provided support alongside her treatment. This was despite the impacts of the pandemic. It has been identified that a wider community understanding of domestic abuse and access to support services needs to be part of the ongoing work in Herefordshire and features as part of the newly established Local Partnership Domestic Abuse Board.

15. Conclusions

15.1 Gee Gee was a loving wife and mother who felt a responsibility to maintain a stable and caring home for her family, even as she grew older and needed that care for herself. She felt unable to challenge the behaviours of her sons and could not engage the help of professionals because they were adults who had full capacity and therefore agency engagement could only be with their consent.

15.2 The description of the stresses at home by family and friends is not reflected in the description of the tensions by agencies who had engaged with Gee Gee. She did not provide detail or disclosure of the situation in the home. She is described as a very private person and coming from a generation where you dealt with your problems within your family rather than with outside agencies. This is not uncommon in older generations and agencies should be cognisant of this fact in their dealings with older people, asking supplementary questions and being aware that situations may be diminished by individuals in their descriptions.

15.3 There were opportunities when domestic abuse was disclosed, particularly by the perpetrator, when referrals to partner agencies should have been completed in order that further assessments could have been conducted.

15.4 The mental health of the perpetrator only deteriorated in the days leading up to the homicide, this was not conveyed to professionals. He had never displayed any physical violence towards any family member previously and was not considered to be a risk.

There has not been anything identified in this review that changes that position and therefore no agency could have intervened at an earlier stage.

16. Overview Recommendations

16.1 **Recommendation 1**: Because of the national pandemic ways of working have had to change dramatically and at pace, including face to face appointments. Many services have been flexible in their approach, and this is recognised in this review. The importance of face-to-face consultation is recognised by this review and if this cannot be conducted on a personal level the use of video calling should always be considered alongside telephone and online consultation. This recommendation should be viewed to become incorporated in either future digital strategies or service provider policies around accessibility.

16.2 **Recommendation 2:** Herefordshire Community Safety Partnership to continue to raise awareness within local communities of the help available for domestic abuse and mental health services. Alongside the VAWG strategy to include male victims of domestic abuse and the older generation.

There has been significant highlighting on a national scale throughout the pandemic regarding the importance of raising community awareness around domestic abuse. This recommendation recognises this, along with the necessity to maintain messaging.

16.3 **Recommendation 3:** Herefordshire Community Safety Partnership to raise awareness with relevant frontline staff around Adverse Childhood Experiences (ACE's) and the ongoing impact of these experiences into adulthood.

16.4 All agencies to consider broadening the knowledge of their staff around Adverse Childhood Experiences (ACE's) and the ongoing impact of these experiences into adulthood.

16.5 **Recommendation 4:** Adult Social Care to treat all Safeguarding Concerns which include elements of potential domestic abuse to be listed as RED by Safeguarding Adults Team and worked on within two working days to decide if they need to progress to Section 42 Safeguarding Enquiry.

16.6 **Recommendation 5:** Adult Social Care to ensure all Safeguarding Concerns which involve potential domestic abuse to involve consultation with police to clarify if there have been previous events of domestic abuse and to gain police perspective. This is to be recorded in the case records. The legal gateway for this is the prevention and detection of crime.

16.7 **Recommendation 6:** Adult Social Care to consider all Safeguarding Concerns which involve potential domestic abuse to consider referral to West Mercia Women's Aid Helpline where the most appropriate support service can be engaged. IDVA for high risk and community-based support for low-med risk cases. As part of this Safeguarding Adults Team to invite West Midlands Women's Aid to discuss the work of IDVA's.

16.8 **Recommendation 7:** Adult Social Care to engage with Workforce Development to see if training focused on Domestic Abuse and customers who may be eligible for support from Adult Social Care can be commissioned.

16.9 **Recommendation 8**: WVNHST considers recruitment of a nominated individual as domestic abuse lead to have strategic oversight of the awareness training and support provided to victims of domestic abuse. This individual would lead at a strategic level including attendance at strategic Community Safety Partnership Domestic Abuse meetings. It is noted that there is currently no funding available for the role.

16.10 **Recommendation 9**: To implement mandatory Domestic abuse training in the WVNHST. This recommendation interlinks with the strategic lead recommendation.

16.11 **Recommendation 10:** A&E introduce a mandatory field in their electronic system so that at triage all adults aged 18 and over, both male and female, are asked five questions which will help to identify potential abuse, domestic or otherwise. This recommendation is already being progressed.

Action Plan

Agency.	Recommendation/Action.	Target Date	Monitoring Agency	How will it be measured
All Agencies	The digital strategy of agencies to embed as business as usual the use of technology to facilitate consultations. Through the use of telephone, video calling and other digital conference management.	Ongoing		Strategic oversight of the Policy. Availability of the facility If viable data collection for number of consultations conducted via digital technology to be part of performance monitoring
Herefordshire Community Safety Partnership	The ongoing community engagement to arrange awareness within local communities of the services available to support domestic abuse and mental health. In addition to the VAWG strategy to be cognisant of male and older victims	Ongoing and delivered during this review	Local Partnership Board	Through increased accessibility: Already delivering by positive promotion of services aimed at male victims of DA Through regular meeting of the local partnership board
All Agencies	To increase awareness of staff around Adverse Childhood Experiences and ongoing experiences into adulthood	Ongoing	Training	Devising the training package Recording the number of staff to whom the training has been delivered

Adult Social Care	To have effective response to safeguarding concerns with domestic abuse. this includes timeliness (2 days) and multi-agency information sharing.	Completed		Funding has been secured to recruit additional staff to work within the MASH to address adult safeguarding concerns. All safeguarding concerns listed as RED are now processed within two working days. As this protocol has evolved so has the referrals to Women's Aid
Adult Social Care	To commission training on domestic abuse	Ongoing	Finance & work force development	The application for funding has been submitted and is still being considered. It is the lack of funding that has inhibited progression of this action
WVNHST	To Consider recruitment of a nominated individual as domestic abuse lead to have strategic oversight & implement mandatory domestic abuse training	Ongoing	Strategic Board WVNHST	This is on the risk register and awaits funding. The training is interlinked with a strategic lead and funding formula

WVNHST	A&E to in traduce a mandatory field in their electronic admissions system to incorporate asking all adults questions to identify potential abuse	Ongoing		This action is currently being developed with the IT teams and should be completed within 12 months

APPENDIX A

Terms of reference for the review

The Terms of Reference for this DHR are divided into two categories:
specific questions which need only be answered by the agency to which they are directed; and

where applicable, generic questions should be clearly addressed in summary reports or IMRs. Summary reports will only be required where agencies demonstrate during scoping that they have little involvement with either the victim or perpetrator.

a. Agencies are asked to respond to these specific questions:

Gee Gee had a professional social care background did this influence her responses to professionals a result. Did her knowledge and awareness from this mean she was able to deal with or reassure other professionals that she was safe/not at risk?

Were there missed opportunities for support for Gee Gee or the family for onward referral / Vulnerable Adult Risk Management (VARM) considerations (now referred to as Complex Adult Risk Management (CARM))

What was the impact of son's mental health on Gee Gee and her ability to cope with her sons' behaviours?

Would there have been a different response if they were teenage not adult children?

Did the lockdown effect the responses given to the family?

Did agencies consider the family holistically, consider what else is going on in people's lives?

b. Generic Questions

Were practitioners sensitive to the needs of the victim and the perpetrator, knowledgeable about potential indicators of domestic violence and abuse and aware of what to do if they had concerns about a victim or perpetrator? Was it reasonable to expect them, given their level of training and knowledge, to fulfil these expectations?

Did the agency have policies and procedures for Domestic Abuse, Stalking and Honour Based Violence (DASH) risk assessment and risk management for domestic violence and abuse victims or perpetrators and were those assessments correctly used in the case of this victim/perpetrator? Did the agency have policies and procedures in place for dealing with concerns about domestic violence and abuse? Were these assessment tools, procedures and policies professionally accepted as being effective? Was the victim subject to a MARAC or other multi-agency forum?

Did the agency comply with domestic violence and abuse protocols agreed with other agencies, including any information-sharing protocols?

What were the key points or opportunities for assessment and decision making in this case? Do assessments and decisions appear to have been reached in an informed and professional way?

Did actions or risk management plans fit with the assessment and decisions made? Were appropriate services offered or provided, or relevant enquiries made in the light of the assessments, given what was known or what should have been known at the time?

When, and in what way, were the victim’s wishes and feelings ascertained and considered? Is it reasonable to assume that the wishes of the victim should have been known? Was the victim informed of options/choices to make informed decisions? Were they signposted to other agencies?

Was anything known about the perpetrator? For example, were they being managed under MAPPA? Were there any injunctions or protection orders that were, or previously had been, in place?

Had the victim disclosed to any practitioners or professionals and, if so, was the response appropriate?

Was this information recorded and shared, where appropriate?

Were procedures sensitive to the ethnic, cultural, linguistic and religious identity of the victim, the perpetrator and their families? Was consideration for vulnerability and disability necessary? Were any of the other protected characteristics relevant in this case?

Were senior managers or other agencies and professionals involved at the appropriate points?

Are there other questions that may be appropriate and could add to the content of the case? For example, was the domestic homicide the only one that had been committed in this area for a number of years?

Are there ways of working effectively that could be passed on to other organisations or individuals?

Are there lessons to be learned from this case relating to the way in which this agency works to safeguard victims and promote their welfare, or the way it identifies, assesses and manages the risks? Where can practice be improved? Are there implications for ways of working, training, management and supervision, working in partnership with other agencies and resources?

Did any staff make use of available training?

Did any restructuring during the period under review likely to have had an impact on the quality of the service delivered?

How accessible were the services for the victim?

APPENDIX B

Glossary

A&E	Accident and Emergency
ASC	Adult Social Care
CAHTT	Crisis and Home Management Team
CARM	Complex Adult Risk Management
CCG	Clinical Commissioning Group
CSP	Community Safety Partnership
DASH	Domestic Abuse Stalking and Honour Based Violence Risk Assessment
GP	General Practitioner
HWHCT	Hereford & Worcestershire Health Care NHS Trust
HCSP	Hereford Community Safety Partnership
IDVA	Independent Domestic Violence Advisor
IMR	Individual Management Records
MAPPA	Multi Agency Public Protection Arrangements
MARAC	Multi Agency Risk Assessment Conference
SIO	Senior Investigating Officer (Police)
VARM	Vulnerable Adult Risk Management
WVT	Wye Valley NHS Trust

APPENDIX B

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APPENDIX D

Executive Summary

Herefordshire Community Safety Partnership

Victim is Gee Gee (Pseudonym) who died in January 2021

Author Julie Mackay

Report completed May 2022

1. This summary outlines the process undertaken by Herefordshire Community Safety Partnership domestic homicide review panel in reviewing the homicide of Gee Gee who was a resident in their area.

2. The following Pseudonyms have been used in this review for the victim, Gee Gee, the perpetrator, Peter, the victim's husband, Frank and the victim's other son, Robert in order to protect the identities of those involved and their families. The victim was a lady in her 80's, the perpetrator was in his 50's.

3. All parties involved in this case are white British, the identified protected characteristics are age and disability (mental health). Gender has also been considered in the context of male victims of domestic abuse being recognised and the relevant support policies and processes being present.

4. Involvement of the family was limited to Gee Gee's husband, Frank. Letters were sent to the perpetrator and other son giving an opportunity to be part of the review, but no response was received. Friends of the family were also contacted, and they did provide some insight.

5. Criminal proceedings were completed in April 2022. The perpetrator was found guilty of manslaughter, diminished responsibility and given a Mental Health Hybrid order (section 45a) and is currently detained in a secure hospital.

6. The process began with a referral by West Mercia Police 4th February 2021 to Herefordshire Community Partnership who conducted a rapid review and the decision to hold a domestic homicide review was agreed. All agencies that had potentially contact with the victim and perpetrator prior to the death were contacted and asked to confirm whether they had any involvement with them. Those who did were asked to secure their files and subsequently provide Information Management Reports (IMR's)

7. The following agencies were represented, and they had all provided IMR's that were independently prepared. Herefordshire and Worcestershire Clinical Commissioning Group (CCG) Represented by the Director for Nursing and Quality; Herefordshire Council Adult Social Care (ASC) represented by the Assistant Director for ASC

operations; Herefordshire Public Health represented by a public health specialist; West Mercia Police represented by a Detective Inspector ;Wye Valley NHS Trust represented by an advanced practitioner for Adult Safeguarding ; Herefordshire and Worcestershire clinical commissioning group represented by deputy designated nurse for safeguarding ;Herefordshire and Worcestershire Health & Care NHS trust represented by the safeguarding services manager; West Mercia Women's Aid represented by the county manager.

8. The panel met on a total of four occasions.

9. The independent author Julie Mackay, a retired Police officer with an extensive background investigating homicide and domestic abuse and conducting independent review for HM Coroner for the Inquests into the victims of a serial killer.

10. Terms of Reference for this review were agreed and these specific questions were considered alongside generic questions. The time period was from January 2020, but when other significant contact was identified, this was extended to include the earlier time period, specifically in 2019.

i.) Gee Gee had a professional social care background did this influence her responses to professionals a result. Did her knowledge and awareness from this mean she was able to deal with or reassure other professionals that she was safe/not at risk?

ii.) Were there missed opportunities for support for Gee Gee or the family for onward referral / Vulnerable Adult Risk Management (VARM) considerations (now referred to as Complex Adult Risk Management (CARM))

iii.) What was the impact of son's mental health on Gee Gee and her ability to cope with her sons' behaviours?

iv.) Would there have been a different response if they were teenage not adult children?

v.) Did the lockdown effect the responses given to the family?

vi.) Did agencies consider the family holistically, consider what else is going on in people's lives?

11. Gee Gee had been married to Frank for 34 years, she had two sons from her marriage to her first husband, Peter (perpetrator) and Robert. Both sons, now aged over 55 years resided at the family home with Gee Gee and Frank and had done so for a significant number of years following their respective relationship break ups.

12. Gee Gee had some health issues, which she continued to receive treatment for throughout lockdown. This included access to her GP and specialist services. A number of appointments were transferred to telephone or an option of video appointments.

13. Gee Gee referred to stress at home caused by the behaviour of her sons but did not provide any detail and in fact referred on one occasion to being aware of risk and not considering that there was any risk.

14. Vulnerability due to age and mental health (she was receiving ongoing treatment for depression) was not overtly identified, but consideration was given to her capacity and whether she met the criteria for Complex Adult Risk Management (CARM). She was specifically asked if she would like a referral to be made to other agencies for further support. This offer was declined.

15. Gee Gee had a good relationship with her GP and had regular contact throughout the review period. Her description of the behaviour of her sons at home was interpreted as low level family arguments and did not reflect the description that she provided to a friend which was of a much more volatile situation.

16. On one occasion Gee Gee did disclose that there was abuse occurring within the family, she did not consider herself to be a victim, but would have qualified for additional support. She was offered the opportunity to be referred to other agencies but declined this option. She did agree for a referral to be made to the police for a marker to be placed on her address in the event that there were further incidents and the police needed to be called.

17. This marker was not placed, it seems due to the referral not being received by the police. As no contact was ever made it did not have an adverse impact.

18. No access to any records in relation to Robert was granted and therefore any descriptions of his behaviour have been provided by friends and family. He is not the perpetrator and therefore not subject to this review. It was apparent though that his behaviour, which was described as aggressive towards his brother, Peter, and stepfather, Frank, did constitute domestic abuse but was not recognised as such by either the parties involved or any agency that disclosure was made to.

19. The perpetrator Peter is described as having mental health issues in the form of depression and had been treated for this for more than twelve months thus making it a protected characteristic. He did present to different agencies including the NHS Wye Valley trust (A&E) and his GP and was receiving support from independent mental health support providers. He did disclose to one of these providers that he found the situation with his brother challenging and the lack of intervention by his mother, Gee Gee, left him feeling isolated and unsupported.

20. Peter was not identified as an adult who should have been managed under CARM and on one occasion where he disclosed that he was the victim of domestic abuse (by his brother) no onward referral was made to other agencies.

21. In the days leading up to Gee Gee's death the family and friends have described a decline in the behaviour of the perpetrator. On the day before her death Gee Gee did contact her GP regarding his condition. She described to the GP physical symptoms and the GP did speak with Peter. It was agreed to conduct an examination of Peter the following day, and this appointment was made at a time that could also accommodate a medical appointment that Gee Gee had.

22. Gee Gee's disclosure to her friend that evening in respect of Peter's behaviours focussed upon mental health symptoms and behaviours.

23. On the day of her death Gee Gee again contacted her GP and described a deterioration in the mental health of Peter. The response from the mental health support team was immediate and arrangements were made for Peter to be seen by mental health professionals that afternoon. The delay was to allow Gee Gee to retain her own medical appointment. Peter had never displayed any violent tendencies towards any family member and was not considered to pose a risk to either himself or others.

24. Prior to being seen by mental health professionals, Peter fatally wounded Gee Gee at their home. Present at the time was her other son Robert.

25. The analysis of this review has identified long standing patterns of behaviour within the household that did constitute domestic abuse. These behaviours were not recognised as such by those who were victims, this seems to be due to a variety of factors:

    - The victims were male and did not identify themselves as victims
    - Support services available to male victims of domestic abuse are through women's aid. The male victim(s) stated they would not consider contacting women's aid for their own help/support
    - Gee Gee was an older lady (over 80 years) who was also very private and protective of her family. She declined any support.
    - Gee Gee felt protective and responsible for her son's and was fearful of the negative impact if she either asked them to leave or sought external help
    - Services that engaged with the victim and perpetrator took the descriptions of unrest at home to be standard family falling's out. This is compounded by lack of disclosure versus missing the occasional opportunity to make an onward referral.

26. The lack of self-recognition and the limited disclosure to agencies involved in the family meant that where there were support services and agencies available these were not utilised.

27. There were occasions when the perpetrator disclosed being the victim of domestic abuse to professionals. This was not identified as such and consequently the relevant referrals to other agencies were not made.

28. The lessons to be learnt and recommendations made during this review have where possible already been acted upon. Those that cannot be progressed are not only recorded in this document but in some cases form part of wider strategic oversight and are either on a risk register or encompassed in ongoing action plans.

29. The impact of the pandemic on the individuals and their accessibility to services has been considered throughout. The conclusions drawn in respect of this are that all services remained available. The way appointments were conducted was changed from face to face to a mixture of phone calls, video calls and face to face

appointments. In some instances, it is the view of family members that conducting online appointments provided challenges around confidentiality and the ability to speak freely (all family members were present and living in the same house with little privacy). There is evidence that agencies were aware of this, noting that the person seemed unable to speak freely.

30. There was also a view by a family member that had agencies been able to see how the perpetrator was presenting when receiving counselling and the night before the death of Gee Gee they may have been more informed. It is not possible to ascertain whether this would have had any influence on the decision making at that time.

31. When it was apparent that the perpetrator did need additional mental health support it was made available immediately, on the day of Gee Gee's death. The risk of harm to either the perpetrator or anyone else could not have been predicted as there was no history of violence, and the risk was assessed with all available information as low.

32. The question as to whether there would have been a different approach if it were children involved has been considered by all agencies. There would have been a holistic overview of the family if they were children with the option of a multi-agency safeguarding meeting. This option was and still is available in the case of adult children residing at home, there was more of an onus on the agency to identify and call for such a meeting. The recent establishment of the multi-agency adult safeguarding hub provides the ability for that holistic oversight if the disclosure is received.

33. The recommendations are as follows.

- Digital strategies to include the continued use of telephone and video appointments alongside face to face.
- Continue to raise awareness of domestic abuse in the older generation and male victims. This has already been progressed with a variety of campaigns supported by Hereford and Worcester Women's Aid
- Training packages for staff to include Adverse Childhood Experiences (ACE's)
- Adult social care referrals and information sharing for safeguard concerns to be timely and include the Police and Women's aid. This is already being embedded through the safeguarding hub that has recently been established.
- Domestic abuse training to be established for both adult social care and the Wye Valley National Healthcare trust. This is related to funding issues and continues to be identified as a training need.
- WVNHST to identify a strategic lead for domestic abuse. This is recognised and is currently on the risk register
- A&E to introduce mandatory question set for all patients to identify potential victims of abuse. This program is currently under development.

34. The overall conclusion from this review was that there are some areas where lessons can be learnt, or improvements made. Many of these are either already in tranche or awaiting the requisite funding. The impact of lockdown was felt within the family dynamics but there was still access to services. The perpetrator had no history of violence and had shown improvements in his mental health until the day before

the offence. There was nothing in his behaviour that indicated to either professionals or family members that he could or would commit this offence.