DHR Executive Summary into the death of Michelle

March 2022

Cheltenham Community Safety Partnership

Report author: Shona Priddey

Report Completed: September 2024

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The Review Process

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

The Victim's own name was used in the Report in accordance with the Families wishes. Michelle was 47 years of age, Female and White British.

The following pseudonyms have been used in this review for the perpetrator and other parties as appropriate to protect their identities and those of their family members:

The perpetrator's pseudonym is Frank, and he was 19 years of age at the time of the fatal incident, Frank is Male and White British. Frank is Michelle's Son.
Michelle's other Son has been referred to as Older Son in the Report and their Father, Michelle's Ex-Husband has been referred to as her Ex-husband in the Report. Both parties are Male and White British.

Criminal proceedings were completed in September 2023 and the perpetrator offered a guilty plea to manslaughter by reason of diminished responsibility following two psychiatric reports. He was sentenced to a S37 hospital order with S41 restrictions, the latter meaning that he can only be released with the agreement of the Ministry of Justice.

The process began with an initial meeting of the Community Safety Partnership on the 18th of March 2022 when the decision to hold a domestic homicide review was agreed. All agencies that potentially had contact with Michelle and Frank prior to the point of death were contacted and asked to confirm whether they were involved with them.

Six of the Eleven agencies contacted confirmed contact with the victim or perpetrator and were asked to secure their files.

Contributors to the Review

Gloucestershire Constabulary – IMR
Gloucestershire Children's Social Care – IMR
Gloucestershire Domestic Abuse Support Service – Short Report
Gloucestershire Health and Care NHS Foundation Trust – Short Report
South Western Ambulance Service – Short Report
ICB (on behalf of GP) – Chronology and Information
Michelle's Parents – Information
Michelle's Older Son – Information
Michelle's best friend – Information

All IMR authors were independent and had no direct contact or connection with Michelle or Frank.

The Review Panel Members

Independent Chair
Assistant to Independent Chair
Cheltenham Borough Council
Gloucestershire Office of the Police and Crime Commissioner
Gloucestershire Hospitals NHS Foundation Trust
NHS Gloucestershire Integrated Care Board (ICB)
Gloucestershire Health and Care NHS Trust
Gloucestershire County Council
Gloucestershire Probation Service
South Western Ambulance Service NHS Foundation Trust (SWASFT)
Gloucestershire Domestic Abuse Support Services (GDASS)
Gloucestershire County Council
Cheltenham Borough Homes
Gloucestershire Constabulary

None of the Panel members had direct involvement in the case nor had line management responsibility for any of those involved.
The Independent Chair and the Assistant to the Chair are both independent ensuring no conflict of interest.
It was agreed as a Panel for this particular DHR that all Panel members names from agencies would be removed including their roles and job titles from the Report and kept confidential.

The Panel met on four occasions. Further meetings took place with individual Panel members where it was necessary to do so.

Author of the Overview Report

Shona Priddey was appointed by Cheltenham Borough Council, Gloucestershire County Council and Gloucestershire OPCC on behalf of Safer Gloucestershire as the independent Chair and Author for this DHR in May 2022. Shona acts as an independent Chair and Author for DHR's. She has completed the Home Office approved course for Domestic Homicide Review Authors provided by AAFDA. Her background is within the Criminal Justice System both academically and professionally. She is a justice of the peace in both criminal and family courts and holds the position of trustee for a domestic abuse charity (SUTDA). Shona is independent of all the agencies involved in this case and has never worked in Cheltenham or Gloucestershire or for any of its agencies.

Terms of Reference for the Review

Statutory Guidance (Section 2.7) states the purpose of the DHR Review is to:

- Establish what lessons are to be learnt from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims.
- Identify clearly what these lessons are, both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result.
- Apply these lessons to service responses including changes to inform national and local policies and procedures as appropriate.
- Prevent domestic violence and homicide and improve service responses for all victims of domestic violence and abuse, by developing a co-ordinated multi-agency approach to ensure that domestic abuse is identified and responded to at the earliest opportunity.
- Contribute to a better understanding of the nature of domestic abuse.
- Highlight good practice.

Specific terms of reference set for this review

Frank

- Were Frank's mental health problems known to agencies or multi agency forums?
- Was Frank able to access the help and support needed to improve his mental wellbeing?
- Was that support enough considering the disclosures he made about his violent thoughts and thinking he was going to kill someone?
- Was there a history of abusive behaviour by Frank in childhood into adolescence and was this known to any agencies?
- If so, did they take the appropriate steps to support and intervene where they could have?
- Did childhood experiences with Domestic Abuse contribute to Frank's behaviour?

Family and Friends

- The purpose of talking with friends and family is to help gain an understanding of things from Michelle's perspective.
- Were family or friends aware of any abusive behaviour towards Michelle prior to her death?
- Did family or friends experience any barriers in reporting abuse?
- Did agencies communicate effectively with the family and friends?

Agency response

- Did agencies share information and if they did, what did they share?
- Did any agency join the dots? If they did was it done correctly and in a timely manner?
- What more could have been done by agencies?
- Could improvement in any of the following have led to a different outcome:
- Communication and information sharing between services?
- Information sharing between agencies regarding the safeguarding of adults?
- Communication within services?
- Communication and publicity to the public and unknown specialist services about the nature and prevalence of domestic abuse and available local specialist services.
- Was the work undertaken by services in this case consistent with each organisations professional standards and any domestic abuse policy procedures and protocols?
- Has any learning already been identified? If so, has anything been implemented since Michelle's death.

Summary Chronology and Key Issues arising from the review

Michelle lived in Cheltenham with her two sons. Michelle was killed by her youngest son in their family home.

There was a small record of historic domestic abuse towards Michelle by her ex-husband in the family home in 2013 when Michelle had been married to the children's father.

Michelle had left that relationship though and there was very little known of Michelle by agencies other than by her GP due to her poor physical health.

Michelle had a condition called Behcets's Syndrome - a chronic condition associated with the immune system.

Michelle was a loving mother and had doted on her two sons ensuring she was able to teach them both to drive even though she had been largely housebound in recent years due to her physical health and the pain it caused her.

Frank had been known to services briefly as a child due to the incident in his family home regarding his father.

The next interaction between Frank and agencies was in September 2020 when Frank and two passengers in his car were stopped and searched. One of the female passengers was found with three wraps of cannabis and approximately 1 gram of cocaine on her.

Frank came into contact with agencies again in October 2020 when Frank had an argument with his current girlfriend at the time and had pushed her and caused some damage to a glass door. Frank was issued with an Adult Caution in respect of the criminal damage having no previous convictions and admitting culpability.

Frank denied the assault in interview, there was no CCTV of the offence, no injuries caused therefore no photographs, and no complaint from the victim; so, no further action was taken.

GDASS did try several times to contact Frank's girlfriend but there was never any response. Concerns by the girlfriend that evening about Frank's mental health were raised and there have been lessons learnt from this by the Police.

The next interaction between Frank and agencies was on the 14th of March 2022 when he called the Police asking for some assistance with his mental health and after a conversation, he was advised to call the Crisis team. Frank did contact the Crisis team himself and had a relaxed and calm conversation with them.

The last interaction Frank had with agencies was when he called the Police after killing his mother in March 2022.

Conclusions

Michelle had very limited engagement with agencies. Michelle had been a victim of domestic abuse by her ex-husband many years ago but there was no indication or evidence to suggest prior to her murder that Frank had harmed her previously. Michelle was largely house bound due to her illnesses and didn’t like to burden anyone with anything however her Mother visited daily.

Frank had been struggling with his mental health. He had limited engagement with agencies; however, his few engagements involved him being the suspect or perpetrator. With the exception of the 2013 contact when he was a child in a domestic abuse setting. Although the two siblings were not open to Children’s Service, it can be hypothesised that the impact of domestic abuse on their adult lives has been significant.

One of the purposes of a DHR is to prevent domestic abuse and homicide and improve service responses for all domestic violence and abuse victims and their families by developing a coordinated multi-agency approach to ensure that domestic abuse is identified

and responded to effectively and at the earliest opportunity. The panel will identify lessons and make recommendations accordingly.

Lessons to be Learned

This section will summarise what lessons are to be drawn from the case and how those lessons should be translated into recommendations for action. It will also evidence any early learning identified during the review process and whether this has already been acted upon.

-Good practice in decision making when families referred by police or self-refer. This practice shared across CSC.

-Gloucestershire Children's Social Care is currently developing a domestic abuse tool for social workers. This will be used to assess domestic abuse and its impact on children.

-Frank was subject to a pre- release care plan but as no issues had been raised by himself or the OIC in respect of his alcohol use/mental health no referrals were made, and no support agency information was provided. This could have been an opportunity to provide information at least regarding alcohol misuse and violence/DA, considering what he was arrested for. The majority of perpetrators would say they don't have a problem, so it is something to reflect on. Signposting information could be provided even when a referral need has not been identified.

-A learning point was identified regarding police crime recording effectiveness, however from 12th September 2022, "front end criming" has been introduced to ensure any crimes identified on incident logs on STORM are crime recorded within twenty-four hours of report. This new and improved crime recording process would ensure that incidents such as the one on 2nd July 2013 would have had a crime record of Stalking/Harassment created within 24 hours of being reported.

-There was a lack of professional curiosity and record keeping at times by agencies. I will address the October 2020 incident and the March 2022 incident separately.

-In October 2020 when Frank was arrested, and disclosures were made to Police about mutilation and a knife in his car this should have been investigated and if nothing else logged as intelligence that was marked on his record for future safe-guarding purposes for others and future contact with Frank himself with agencies.

-On the night of the 14th of March 2022 when Frank contacted the Police Call handler, Frank was concerned about his thoughts and mentioned killing a few times. The Call Handler asked Frank each time if he was going to harm anyone or himself and Frank said No. Frank asked about this call having any repercussions on future employment as he wanted to join the Army. Frank showed insight into the situation and was clearly thinking about his future. The Police Call Handler did an exemplary job that night and really listened to Frank. They sign posted Frank to the CRHTT and also made sure Frank knew he could call back at any time if things changed. They also called the CRHTT to inform them about Frank and his potential call and they sent across their notes from their call with Frank immediately.

- On the night of the 14th of March 2022 CRHTT Call Handler had the notes regarding the concerns raised by the Police Call Handler whilst speaking with Frank that evening. The information given to the CRHTT by the Police Call Handler was not used to its full potential it would seem after listening to all of the calls; however, they did receive them whilst the call came in from Frank. This presents difficulties as the Call Handler would be having to respond to a live call and engage the caller and try to review the incoming notes whilst not disconnecting with the caller. If the Call Handler had of asked Frank to call back, he might not have done so and the same if he was put on hold for a few minutes, he might have hung up. This is one of those impossible situations where all anyone can do is their best in the given circumstances. This does explain why no questions were asked regarding the disclosures Frank made minutes before to the Police Call Handler about thoughts of killing. Frank had stated he had no intent to harm anyone specifically but his thoughts about it concerned him greatly. Frank did disclose that he “enjoyed the incident at the time of doing it” referring to the incident two years prior concerning his girlfriend although he felt “fear shame and guilt afterwards”. Neither of these statements were questioned or probed, so, there is some learning here. They have access to a psychiatrist so could have used that resource if it was deemed appropriate to do so. The Call Handler could have called the

Police Call Handler back if any concerns had of been raised but that might have only resulted in the Police logging it or a Safe and Well check for Frank but that in itself is learning to come from this tragic incident. However, it is important to emphasise that there is no clear indication from the calls that Frank would go on to kill his Mother or indeed anyone. It is important to acknowledge this fact especially as the Family believe more was disclosed by Frank in these calls but that is not the reality of the situation. Frank was calm and thoughtful during both calls, and he provided a limited amount of information.

- The Police did demonstrate good practice on the 14th of March contacting the CRHTT themselves regarding Frank and their concern for his mental health.

-Family and friends can be an invaluable source of information and support. Whilst there are issues with consent to share information, agencies should seek to establish this consent at the earliest opportunity when it involves their care and safety planning for themselves and their family.

-Public understanding of domestic abuse and how it looks in all its forms, including child on parent violence is still misunderstood and minimised at times by society as a whole.

Recommendations from the Review

Gloucestershire Local Domestic Abuse Partnership Board to consider its response to Child to Parent Abuse and consider options around professional training and what service provision may be required.

-Gloucestershire Local Domestic Abuse Partnership Board to take forward the recommendations from the recent Gloucestershire CYP Needs Assessment, to address gaps in provision for children who witnessed domestic abuse in the home. Frank had witnessed domestic abuse in his family home as a child and it is acknowledged now by professionals that children experience the harm they are witnessing and that they are impacted emotionally and psychologically.

-For the Police to explore with regards to capacity the ability to fully record and log as intelligence any safe guarding or mental health disclosures and to explore options around being able to share between relevant agencies even when not considered high risk at the time. (Listening to the victim –Frank's girlfriend's disclosures were not taken as seriously as they perhaps should have been back in 2020:P.14.16).

- It is unknown if DA training would have helped in this situation, but it is recommended that Gloucestershire Health and Care (GHC) consider making it mandatory in all departments. CRHTT to be reminded about unconscious bias, and using the information shared with them by partner agencies to its full potential. The department does have twenty-four-hour access to a psychiatrist so an area of learning to engage that resource.

- Any disclosures made to be addressed in context using the information already obtained by themselves and other agencies and not to be viewed in isolation.

-A recommendation for the CRHTT to have active listening skills training to allow best practice for the department and their service users.

- The Police to have a DA exit strategy from custody – liaison with services for Signposting relevant services already available in the area.