Domestic Homicide Review (DHR)

Cheltenham Community Safety Partnership

Overview Report for

Michelle - March 2022

Shona Priddey
Overview Report Author
Completed 19th September 2024

MICHELLE

Michelle was very kind, loving and intelligent. She always had a smile for everyone. Michelle was an active child with lots of interests. She was a member of The Brownies, a Judo club and liked to put on dance shows with her friends for neighbours. She also learned to play the guitar. Michelle did well at school, achieving 8 O levels. When she left school, she worked at the insurance company Mercantile & General. At sixteen, Michelle became ill and on her seventeenth birthday was diagnosed with Behcets's Syndrome - a chronic condition associated with the immune system. Her condition worsened and she was prescribed a drug that destroyed her bone marrow placing her in grave danger. Thankfully, medical staff managed to improve her condition. Michelle showed her gratitude by campaigning for Behcet's and managed to raise money that funded a hospital bed in the specialised ward. Michelle married and had two sons who were her everything. During times of illness, the boys would sit on her bed, and they would enjoy watching movies together. Michelle had lots of patience and taught her son to drive. He passed his test first time, and they were over the moon! Michelle's friends would go to her for help and advice in times of need.

Regards,

Parents to Michelle

Preface

This is a Domestic Homicide Review Report referring to the life and death of Michelle.

I would like to begin by expressing my sincere sympathies, and that of the panel, to the family and friends of Michelle and thank them for their engagement. This review has been undertaken in order that lessons can be identified to inform future responses to domestic abuse.

I would like to thank the panel and those that provided chronologies, summary reports and individual management reviews for their time and co-operation.

Domestic Homicide Review Chair and Author

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1. Introduction

1.1 This Domestic Homicide Review (DHR) has been commissioned with due regard to the Domestic Violence, Crime and Victims Act 2004, in response to the death of Michelle.

1.2 This report of a DHR examines agency responses and support given to Michelle, a resident of Cheltenham prior to the point of her death in March 2022.Michelle was unlawfully killed by her younger son. A pseudonym will be used in this report for the perpetrator and that will be the name Frank, as agreed with the family.

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

1.4 The review considers agencies contact and involvement with Michelle and Frank from 1st March 2020 to March 2022.The panel agreed that this timeframe reflected the issues identified through scoping and contact with agencies in respect of these. The panel were asked to consider and submit any other significant information outside of the timescales set.

1.5 The key purpose for undertaking DHRs is to enable lessons to be learned from homicides and suicides where a person is killed or died because of domestic violence and abuse. For these lessons to be learned as widely and thoroughly as possible, professionals need to be able to understand fully what happened in each homicide and suicide, and most importantly, what needs to change to reduce the risk of such tragedies happening in the future.

1.6 The aim of this domestic homicide review (DHR) is to:
Establish the facts that led to the tragic death of Michelle in March 2022 and whether there are any lessons to be learned from the case about the way in which local professionals and agencies worked together to safeguard Michelle. The aims from the statutory guidance for a DHR will be covered within the terms of reference in this report.

1.7 This review process has been conducted with an open mindset to avoid hindsight bias. Those leading the review have sought the views of family members and have made every effort to manage the process with compassion and sensitivity.

2. Timescales

2.1 On 18th March 2022 Cheltenham Borough Council (as convenor of Cheltenham Community Safety Partnership) and Safer Gloucestershire (the County Community Safety Partnership) were notified about the death of Michelle in March 2022 which required consideration as to whether a DHR should be undertaken.

2.2 After discussions between the two chairs of the partnerships, lead officers and the responsible cabinet member, it was agreed that the partnerships should jointly commission a DHR. Potential panel members were notified on 4th April 2022.

2.3 Shona Priddey was appointed as Independent Chair of the review panel and Author of the DHR report in May 2022.

2.4 The family were visited by the Chair on the 2nd of August 2022. The Chair had contacted the family's victim support homicide case worker prior to the meeting so they were in attendance as requested by the family.

2.5 This first panel meeting took place on the 16th of August 2022.
Agencies were asked to provide chronologies to assist with formulation of the Terms of Reference.

2.6 The Criminal trial was due to take place in September 2022 but was postponed. It was advised to stop contact with the family until after the trial. The Chair wrote accordingly to both the family and their homicide support worker to explain the current situation.

2.7 The Terms of reference were sent out to the Panel by 4th October 2022 and any amendments or queries were received by 17th October 2022.

2.8 The IMR's and short reports were received by the 6th of March 2023.

2.9 The second panel meeting took place on the 10th of March 2023 to discuss the IMR's and short reports and an update was given by the Police on the criminal trial.

2.10 The first draft overview report was completed by the 28th of April 2023.The review process was then paused for several months until the criminal trial was concluded as the family were witnesses in the trial.

2.11 This review has not been completed within the recommended six-month timeframe due to the criminal trial being delayed twice. The family are willing to engage in this review, so it is necessary and proportionate to delay the review and for it to exceed the recommended timeframe.

2.12 The trial took place in September 2023. Frank 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.

3. Confidentiality

3.1 The findings of this review are confidential. Information is available only to participating officers/professionals and their line managers at this point in time. A pseudonym is used for the perpetrator in the report but the family wish for the victim's real name to be used. The report will be published following Home Office Quality Assurance.

3.2 The victim was female white British and 47 years of age at the time of the fatal incident. The perpetrator was male 19 years of age at the time of the fatal incident and is white British.

4. Terms of Reference

4.1 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.

4.2 Specific terms of reference set for this review:

4.3 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?

4.4 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?

4.5 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.

5. Methodology

5.1 The method for conducting DHR's is prescribed by the Home Office Guidelines. These guidelines state: "Reviews should illuminate the past to make the future safer and it follows therefore that reviews should be professionally curious, find the trail of abuse and identify which agencies had contact with the victim, perpetrator or family and which agencies were in contact with each other. From this position, appropriate solutions can be recommended to help recognise abuse and either signpost victims to suitable support or design safer interventions".

5.2 Following the decision to undertake the review, all agencies were asked to check their records about any interaction with Michelle and Frank. Where it was established that there

had been contact all agencies promptly secured all relevant documents, and those who could make an appropriate contribution were invited to become panel members. The panel also included members with expertise in relevant subject matters. Agencies that were deemed to have relevant contact were then asked to provide an IMR or a summary report and a chronology detailing the specific nature of that contact.

5.3 The aim of the IMR is to look openly and critically at individual and organisational practice to see whether the case indicates that changes could or should be made to agency policies and practice.

5.4 Each agency's IMR or summary report covered details of their interactions with Michelle and Frank, and whether they had followed internal procedures. Where appropriate the report writers made recommendations relevant to their own agencies and prepared action plans to address them. Participating agencies were advised to ensure their actions were taken to address lessons learnt as early as possible.

5.5 The findings from the IMR reports and summary reports were endorsed, and quality assured by senior officers within the respective organisations who commissioned the report and who are responsible for ensuring that the recommendations within the IMRs are implemented.

5.6 On request from the independent chair some authors provided additional information to clarify issues raised individually and collectively within the IMRs. Contact was made directly with those agencies outside of the formal panel meetings.

5.7 Those agencies who provided IMRs or summary reports are detailed within section 7 of this report.

6. Involvement of Family, Friends, Work Colleagues, Neighbours and Wider Community

6.1 Michelle's family have been involved with the review process and have been represented by her mother, father, and eldest son. They have been supported by their Victim Support

Homicide case worker. The Review Chair and Author has met with the family in their own home on several occasions.

6.2 The Review Chair has spoken at length with Michelle's best friend.

7. Contributors to the Review

7.1 The agencies that have contributed to this review are as follows:

- 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.

7.2 IMR authors and report authors were independent with no direct involvement in the case, or line management responsibility for any of those involved.

8. The Review Panel Members

8.1 The following agencies constitute the DHR panel: *

Agency
Independent Reviewer -Chair and Author
Cheltenham Borough Council
Gloucestershire OPCC
Gloucestershire Hospitals NHS Foundation Trust
NHS Gloucestershire Integrated Care Board (ICB)
Gloucestershire Health & Care NHS Trust
Gloucestershire County Council
Gloucestershire Probation Service South Western Ambulance Service NHS Foundation Trust (SWASFT)

Agency
Gloucestershire Domestic Abuse Support Services (GDASS)
Gloucestershire County Council
Cheltenham Borough Homes
Gloucestershire Constabulary

8.2 Independence and impartiality are fundamental principles for a DHR. It is essential that all panel members including the Chair and Author are impartial to ensure the report is legitimate and credible. All panel members meet the criteria, and no one had any direct involvement in the case, or had line management responsibility for any of the practitioners involved.

9. Author of the Overview Report

9.1 Cheltenham Borough Council, Gloucestershire County Council and Gloucestershire OPCC on behalf of Safer Gloucestershire appointed Shona Priddey as independent Chair and Author for this DHR. 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. 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.

***Panel members names have been omitted due to a safeguarding concern. The Chair is the only name to remain due to the direct family contact.**

10. Parallel Reviews

10.1 Criminal Proceedings only. No Coronial Process.

11. Equality and Diversity

11.1 The nine protected characteristics in the Equality Act 2010 were assessed for relevance to the Review.

11.2 Michelle was a forty-seven-year-old white British woman who suffered from Bechet's disease, Psoriatic Arthritis and Osteopenia. The perpetrator Frank was a nineteen-year-old white British male. According to an annual review of DHRs, eighty percent of victims are female, and eighty-three percent of perpetrators were male. For twenty-seven percent of the victims there was a family relationship between the victim and perpetrator.

11.3 Seventy-one percent of perpetrators were considered to have a vulnerability and the most common were: illicit drug use, mental ill-health, and problematic alcohol use.

11.4 The intersectionality between substance misuse, mental health and D.A. is a complex cycle where the substance abuse can exacerbate or cause mental health conditions and increase the risk of D.A. Frank's mental health declined as his substance misuse intensified and ultimately all these factors led to the Matricide. Most Matricides occur in the family home and have elements of "overkill", both factors were present in this case.

11.5 Approximately sixty percent of perpetrators were indicated to have previous offending history. Of these three quarters had abused previous partners and one third family members. This includes a small proportion who had abused both previous partners and family members.

11.6 In consideration of the nine protected characteristics there is no direct evidence that these negatively affected Michelle's access to services. However, her role as a Mother to the perpetrator Frank, may have affected her accessing services for help and support as is suggested in the research into Child on Parent Violence (CPV).

12. Dissemination

12.1 In accordance with Home Office guidance all agencies and the family of Michelle are aware that the final Overview Report will be published. IMR reports will not be made publicly available. Key issues if identified will be shared with specific organisations. The

report will be shared with Safer Gloucestershire and Cheltenham CSP for sign off prior to submission to the Home Office. The Overview Report will not be disseminated until clearance has been received from the Home Office Quality Assurance Group.

12.2 The content of the Overview Report will be suitably anonymised if it is necessary to protect the identity of the female who was killed and relevant family members. The Overview Report will be produced in a format that is suitable for publication with any suggested redactions before publication.

13. Background Information (The Facts)

13.1 Michelle lived in a semi-detached home in Cheltenham, Gloucestershire. At the time of her death, she was 47 years old, and her two sons aged 19 and 22 both lived with her.

13.2 In March 2022 Michelle was found deceased at home in the living room by her mother. An Ambulance was called for.

13.3 Ambulance alerted Police to a 47-year-old female who had been found by her Mum with blood everywhere who appeared to be dead. Paramedics informed Police officers who attended that the victim had multiple stab wounds to her face.

13.4 Michelle's mother had commented that Michelle's younger son's (Frank) car had been on the driveway when she had first attended to walk Michelle's dog but that it was not present when she shortly returned from walking the dog and found her daughter deceased.

13.5 Frank had contacted Police stating he had killed someone and that his Mother was unconscious at her home address. Frank was arrested on suspicion of Murder from the Public House he had driven to after the offence.

13.6 Frank was charged by the CPS on 17th March 2022 and remanded into Custody. In September 2023 Frank 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.

14. Chronology

Some of the entries are outside the timescale set by the TOR, the reason for their inclusion is that the panel agreed they were relevant to the report and its findings.

2013

14.1 Michelle first came to police attention in 2013 at the age of 38 when her Mother contacted Police regarding her ex-husband attending her home address trying to get in.

14.2 There have been submissions of two VIST (Vulnerable Incident Screening Tool) DASH (Domestic Abuse, Stalking, Harassment and Honour Based Violence Assessment) assessments creating two linked Enquiry Logs from 2013.

14.3 Michelle had two children.

- Elder son (Father -Michelle's ex-husband) – He features on both enquiry links from 2013.
- Frank younger son (Father -Michelle's ex-husband)
  – He features on both enquiry links from 2013.

14.4 Enquiry Log relating to the incident on 12th June 2013 states that Michelle's Mother contacted Police as Michelle's estranged husband was trying to get in her home and was banging on the door. He was also trying to talk to the children through the door. The caller stated that Michelle had moved out due to Domestic Violence. He had informed Police he

wanted to see his children and he was sent on his way with no offences identified. Police submit a standard risk DASH.

14.5 14th June 2013 – Police referral (Standard risk DASH). Issues around child contact. GDASS were unsuccessful in engaging with Michelle on the number provided. Case closed 20th June 2013.

14.6 Enquiry Log relating to the incident on 2nd July 2013 states that Michelle contacts Police stating she had recently split from her husband due to him getting drunk and smashing the family home up on several occasions. Michelle reports he has been continually texting her and he turned up at her sons' school shouting and swearing at her in front of the children. Michelle informs Police she had to move in with her parents away from the marital home. Michelle believes he has a problem with alcohol and was in the process of arranging mediation and official child contact agreements, but she stated that he was constantly bad mouthing her to the children and asking them to choose between them. Michelle asks Police to deliver "words of advice" to him to stop the unnecessary contact as she stated they needed to communicate regarding the children. Michelle updates Police three days later stating he had followed her in his works van when she had taken the children to school in the morning. Police OIC contacts him the following day and he agrees he will only contact Michelle via a solicitor and Michelle was updated with this.

14.7 5th July 2013 case referred by Children's Social Care to the Data Action Response Plan (DARP) meeting due to a police incident on 2nd July 2013.Michelle said her estranged husband was constantly texting her and turning up. Today he has been to their sons' school. Michelle currently living with her parents. Michelle noted he has historically punched walls and headbutted doors. There are no protective orders in place. He allegedly badmouths Michelle to the children and uses child contact to continue the abuse. Michelle stated she is afraid of him; she feels isolated and suicidal. She stated that he is stalking her and refusing to pay the mortgage or anything toward the children.

14.8 Michelle was considered to be protective of the children. CSC did have a concern regarding an individual who may have had contact with the children; however, Michelle was sufficiently protective of the children and the case was closed.

14.9 GDASS on 8th July 2013 contacted Michelle. She explained that she has been to see a solicitor about the marital home as her estranged husband is currently living there and she is living with her parents and the children. She is not currently allowing him contact with the children as she stated he just uses this opportunity to say abusive things about her to the kids. Michelle reported that he has turned up at the school and was asking the children to choose who they wanted to live with. Discussed family court process and residency order. Michelle advised that she had spilt up with him eight weeks ago and the decision was mutual as they were not getting on however, she was the one who decided to leave after he urinated all over the kitchen and smashed it up which her 10-year-old son woke up to. They are due to start family mediation and GDASS advised this route may not work due to domestic abuse. Michelle said that there was an incident on Friday where he followed her on the school run and was tailgating her. She reported this to the Police. GDASS details were provided, and she was advised to make contact if family mediation doesn't work or if the situation escalates in anyway. GDASS also advised her to call the Police if there are any further incidents. Case closed.

14.10 Incident Log relating to Michelle on 27th July 2013- Her estranged husband contacts Police stating that Michelle was being obstructive regarding him collecting clothing/possessions of the children. He states that Michelle had sent him a text the day before saying "COME AND PICK UP THE CHILDREN" and the boys were now living with him. He was told to ask a third party to facilitate obtaining items for the children.

14.11 A linked incident on 27th July 2013 is from Michelle's Mother stating Michelle has a rare disease and had been finding it difficult to control the children so in the heat of the moment told the children they could live with their Father who took them back. Michelle had then become concerned for the children's wellbeing as he had been mentally abusive towards Michelle and that was why she had left. Michelle was provided the same advice as her ex-husband in relation to arranging formal arrangements for the children.

14.12 Michelle's younger son first came to Police attention in 2013 at the age of 10 when his Mother and Father separated, and he was noted as one of two children on a VIST/DASH.

2020

14.13 On the evening of the 4th of September 2020 in a car park in Cheltenham a vehicle registered to Frank was parked up with the smell of cannabis coming from it. He was sat in the driver's seat and there were two female passengers. All three were stop searched under section 23 of the Misuse of Drugs Act and one of the female passengers had three wraps of cannabis and approximately 1 gram of cocaine on her. Intelligence was submitted in respect of all three parties and the vehicle.

14.14 On the evening of the 12th of October 2020 Frank is reported to have been drinking excessively and has pushed his girlfriend to the ground and hit her in the chest and face. He has then run away from the scene, which was outside a Public House in Cheltenham and his girlfriend has gone to a friend's address. Later in the evening he has attended the friends address demanding his belongings be returned that he believed his girlfriend had in her possession. When she has tried to close the door, he has kicked it and then put his hand through the window pane smashing it and cutting his hand.

14.15 A VIST containing the DASH for domestic abuse cases was correctly completed and labelled as medium risk. Enquiries with the MASH Manager have confirmed that the VIST was reviewed in the Daily Meeting by Domestic Abuse Safeguarding Team (DAST) and GDASS on the 13th of October 2020.

14.16 The Victim, although not making a formal statement to Police in relation to the allegations, did engage when completing the VIST. Within this she confirms no injuries were caused and she was not frightened/ afraid of further violence. The Victim states that evening Frank had "flipped" and has started "talking about killing people by ripping their faces off". She also stated she believed he had a "personality disorder", no further evidence was provided or reported to support this. She also informed officers that Frank had a kitchen knife in his car and "was chopping the heads off stuffed animals".

14.17 GDASS received a referral via the VIST on 13th October 2020 in relation to the victim (Frank's girlfriend). The VIST stated that Frank's friends reported he had been drinking excessively and started lashing out at everyone who spoke to him. Frank then started shouting at the Victim and when she followed him picking up his belongings, Frank has pushed her to

the ground and hit her in the chest and face whilst she was on the ground- no injuries caused. Frank ran away, later returned to friend's address demanding his belongings back from girlfriend. She tried to then close the door at which point Frank kicked the door. Friend mentioned calling the Police, Frank put his hand through the door window pane, smashing it and cutting his hand. Frank ran off but returned to ask if his girlfriend was okay. Victim states that suspect seemed like an entirely different person during this incident but calmed down nearer the end and returned to normal self. Victim has stated both parties suffer from a form of mental health and suspect is alleged to have a dissociative disorder. Suspect arrested.

14.18 13th October 2020, GDASS sent text to victim (Frank's girlfriend) and no response.

14.19 Positive action was taken as per DA policy with the arrest of Frank who was interviewed and denied the offence of Assault but admitted the Criminal Damage offence. 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, no complaint from the Victim who signed a negative Pocket Notebook entry stating she did not want Frank prosecuted nor did she want to attend Court and no witnesses to the assault. On review of the case the Custody Sergeant authorised the Caution on the Full Code Test and confirmed No Further Action in relation to the assault due to there being no evidence offered and the offence being denied.

14.20 Police conducted the necessary risk assessment with Frank in custody. Frank admitted to having drunk alcohol all day but stated he did not have a dependency on drugs or alcohol. The only injury noted by Frank was that to his hand from punching through the glass. The Custody Sergeant noted that Frank was relaxed and fully engaged with the Self Risk Assessment. Frank did not raise any medical / mental health issues. Frank was seen by the Health Care Professional within Custody in respect of the injuries to his hands and no other issues were raised.

14.21 13th October 2020 Frank was seen by the Criminal Justice Liaison Service (CJLS) during a cell sweep following his arrest on suspicion of ABH against his ex-partner. During the contact CJLT noted no mental health concerns.

14.22 14th October 2020 GDASS make a call to Frank's girlfriend – no response.
14th October – Email to Frank's girlfriend with GDASS information.
14th October 2020 Email reply from Frank's girlfriend saying she does not require support at this time. Case closed.

2022

14.23 14th March 2022 Michelle received advice from a Nurse regarding her Rheumatology it is unknown if she was seen in person by the Nurse.

14.24 14th March 2022 Police contacted the Cheltenham, Crisis, and Home Treatment Team (CRHTT) and reported that Frank had called them and said he was concerned by his thoughts that he might harm others. At the time, he had stated to the police that he had no intention to harm anyone, but that he had read an article that had caused him to reflect. When he had spoken to the police, it is noted that he had made statements to harm others on three occasions while on the phone. The Call Handler had advised Frank to phone the CRHTT, which Frank did.

14.25 Telephone call from Frank to CRHTT is recorded at 21:07 on 14th March 2022.

14.26 Frank told CRHTT staff that he had read an article that had reminded him of an incident that happened in 2020 when he had assaulted his then partner. Since reading the article he had been feeling remorse and guilt about the incident. He denied that he had harmed anyone since this time and denied having any thoughts to harm himself or others at this time. Frank denied experiencing any low mood or anxiety when asked.

14.27 Staff suggested that Frank may benefit from counselling about this past incident and the feelings that it has raised for him. He was signposted to Let's Talk service and given their contact details. It was noted that Frank would consider this. He was encouraged to call Crisis resolution home treatment teams back should he require further support. Frank reported he was staying with his girlfriend that evening.

14.28 One morning in March 2022 SWASFT received a 999 call at 09:17. Ambulance alerted Police to a 48-year-old female who had been found by her Mum with blood everywhere who

appeared to be dead. Paramedics informed Police officers who attended that the victim had multiple stab wounds to her face. The Victim had been found by her Mum at the victim's property. Frank's vehicle had been on the driveway when the Victim's Mother first attended but was not present when she found the Victim.

14.29 Frank contacted Police stating he had killed someone and that his Mother was unconscious at her home address.

14.30 March 2022 Frank was arrested on suspicion of Murder of his Mother from the Public House he had driven to after the offence.

14.31 Frank has one warning marker from March 2022 (Date arrested for Murder) – Suicidal – has attempted to jump in front of a train prior to arrest.

14.32 In March 2022 GHC received a note from Criminal Justice Liaison Service (CJLS), noting that Frank had been arrested at 10:35 hours. Frank was seen by CJLS in custody. CJLS provide an assessment of needs and short-term interventions if required for those arrested and in custody.

14.33 Frank was charged by the CPS on 17th March 2022 and remanded into Custody.

15. Overview

15.1 The overview summarises what information was known about Michelle and the perpetrator Frank, by the agencies and professionals involved. It also includes the views and information known to family and friends.

Overview from family and friends

Michelle's Mother

15.2 Michelle's Mother and Maternal Grandmother of Frank knew nothing about Frank's drug use or any violent episodes and believed that her daughter must have kept that from her

to protect her. She did mention that Frank can get fully absorbed into things such as physical training.

15.3 Michelle's Mother stated that her daughter's poor physical health had impacted on her life considerably and that she helped her out daily with physical tasks such as walking the dog.

15.4 Michelle's Mother didn't want to say anything at this stage about her grandson Frank as she feels protective towards him and loves him. Since the trial is over Michelle's Mother has commented that she was saddened that her grandson Frank, has never said he is sorry for what happened to her daughter Michelle.

15.5 Michelle's Mother is angry and saddened that more wasn't done when Frank called services for help the night before the incident and thinks that as a family if they had of known they could have prevented this.

Michelle's Father

15.6 Michelle's Father wants answers as to why his grandson Frank was not helped when he called in a crisis the night before the incident.
No information was given about his daughter Michelle or Frank his grandson. He finds it too painful to discuss and he hasn't spoken to or visited Frank.

Michelle's Elder Son

15.7 Michelle's elder son believes his brother has a "personality disorder" or "something mentally wrong with him". He states that Frank would tell him that he did. He was aware of his brother's drug taking and thinks it was potentially becoming a problem. He also spoke very negatively about Frank's ex-girlfriend and seemed to blame her for his brother's problems and actions.

15.8 He stated that he and his Father visit Frank in prison as often as they can and have spoken about the death of their Mother. He is aware that his brother tried to reach out for help the night before it happened, and Frank thought he would be arrested and be given help for

his mental health if he told the Police about his thoughts to harm others. His anger is directed towards the Police and the CRHTT and not towards his brother. He only has the narrative his brother has given him about the calls his brother (Frank) made and what was disclosed by him on the 14th of March 2022.

Michelle's Friend

15.9 The Chair spoke with Michelle's best friend since school, and she confirmed that Michelle's boys were her life. Michelle ensured her sons had the best of everything even if she couldn't really afford it. Michelle enjoyed spoiling both of them and particularly enjoyed being able to teach them both to drive and ensuring they passed first time. It was an activity Michelle could do with them as the majority of things were too painful for Michelle to participate in due to the pain she experienced from her illnesses.

15.10 Michelle wasn't one to burden anyone with her problems and for the last few years spent her days at home normally in her bed due to her poor health. In previous years Michelle had looked after her friend's daughter a few days a week and they had both adored each other. Michelle was kind and always there to help others if she could.

15.11 Michelle's friend stated that both boys were normal teenagers. Frank could be highly strung, but she never witnessed any domestic abuse from him towards his mum.

Frank's Work Colleague

15.12 Frank worked for a pizza delivery company and no issues have been raised regarding his behaviour at work.

Overview of Involvement with Gloucestershire Police

15.13 The first contact with the police during the scoping period was made on 4th September 2020 by Frank.

15.14 There are four recorded crimes involving Frank between 4th September 2020 and March 2022.

15.15 On the evening of the 4th of September 2020 in a car park in Cheltenham a vehicle registered to Frank was parked up with the smell of cannabis coming from it. Frank was sat in the driver's seat and there were two female passengers. All three were stop searched under section 23 of the Misuse of Drugs Act and one of the female passengers had three wraps of cannabis and approximately 1 gram of cocaine on her. Intelligence was submitted in respect of all three parties and the vehicle.

15.16 On the evening of the 12th of October 2020 Frank has been drinking excessively and has pushed his girlfriend (Victim) to the ground and hit her in the chest and face. Frank has then run away from the scene, which was outside a Public House in Cheltenham and the Victim has gone to a friend's address. Later in the evening Frank has attended the friends address demanding his belongings be returned that he believed the Victim had in her possession. When she has tried to close the door, Frank has kicked it and then put his hand through the window pane smashing it and cutting his hand.

15.17 A VIST (Vulnerability Identification Screening Tool) was correctly completed and labelled as medium risk. Enquiries with the MASH Manager have confirmed that the VIST was reviewed in the Daily Meeting by DAST and GDASS on the 13th of October 2020.

15.18 The Victim, although not making a formal statement to Police in relation to the allegations, did engage when completing the VIST; within this she confirms no injuries were caused and she was not frightened/ afraid of further violence. The Victim states that that evening Frank had "flipped" and "has started talking about killing people by ripping their faces off". She also stated she believed he had a "personality disorder" (but no information/evidence to support this). She also informed officers that Frank had a kitchen knife in his car and was chopping the heads off stuffed animals.

15.19 Positive action was taken as per DA policy with the arrest of Frank who was interviewed and denied the offence of Assault but admitted the Criminal Damage offence. 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, no complaint from

the Victim who stated she did not want Frank prosecuted nor did she want to attend Court and no witnesses to the assault. On review of the case the Custody Sergeant authorised the Caution on the Full Code Test and confirmed No Further Action in relation to the assault due to there being no evidence offered and the offence being denied.

15.20 Police conducted the necessary risk assessment with Frank in custody. Frank admitted to having drunk alcohol all day but stated he did not have a dependency on drugs or alcohol. The only injury noted by Frank was that to his hand from punching through the glass. The Custody Sergeant noted that Frank was relaxed and fully engaged with the Self Risk Assessment. Frank did not raise any medical / mental health issues. Frank was seen by the Health Care Professional within Custody in respect of the injuries to his hands and no other issues were raised.

15.21 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. It is noted his Mother, Michelle collected him from Custody to take him home. There would be no requirement for the Custody Sgt to have provided any further support or referrals as there had been no information provided to them that this was necessary.

15.22 The next time Police were aware of Frank was the 14th of March 2022, the night before the fatal incident when he called about his mental health. Police call handler signposted Frank to the mental health crisis team.

15.23 In March 2022 Frank was arrested on suspicion of Murder.

Overview of Involvement with GDASS

15.24 13th October 2020 Police VIST received (Medium Risk) referral made in connection with the incident reported to Police on 13th October 2020.

15.25 The VIST GDASS received stated that this appears to be the first incident like this in the relationship. The Victim (Frank's girlfriend) states that: Tonight, he flipped and started

talking about ripping people's faces off. He has problems with mental health and alcohol. He can get angry when other guys flirt with me.
Question asked - Has he ever threatened or attempted suicide before? Yes – he wanted to drink enough to kill himself as life wasn't fun anymore and life wasn't worth living.
Earlier tonight he had a kitchen knife in his car and was chopping stuffed animals heads off.

15.26 On the 13th of October 2020 text to victim (Frank's girlfriend) and no response.
14th October 2020 Call to Victim – no response
14th October – Email to Victim with GDASS information.
14th October 2020 Email reply from Victim saying she does not require support at this time. Case closed.

Overview of Involvement with Gloucestershire Health and Care NHS Foundation Trust (GHC)

15.27 Michelle was not known to GHC physical or mental health services.

15.28 Frank did not have contact with GHC physical health services during the review period.

15.29 Frank did have brief contacts with GHC mental health services during the review period.

15.30 13th October 2020 Frank was seen by the Criminal Justice Liaison Service (CJLS) during a cell sweep following his arrest on suspicion of ABH against his ex-partner.

15.31 During the contact CJLS noted no mental health concerns. Frank reported he had a cut hand when he had smashed a glass the day before, staff observed three fingers were bandaged. Frank reported drinking alcohol twice a week; an information leaflet for 'Change Grow Live' the Drug and Alcohol Support Service for the County was therefore left in his property locker to inform him of the local support service. No further interventions were deemed necessary by the CJLS, and his case was closed.

15.32 14th March 2022 Police contacted the Cheltenham Crisis Resolution and Home Treatment Team (CRHTT) and reported that Frank had called them and said he was concerned by his thoughts – that he might harm others. At the time, he had stated to the police that he had no intention to harm anyone, but that he had read an article that had caused him to reflect. When he had spoken to the police, it is noted that he had made statements to harm others on three occasions while on the phone (details not specified in the GHC clinical notes). The Call Handler had advised Frank to phone the CRHTT, which Frank did.

15.33 Telephone call from Frank to CRHTT is recorded at 21:07.

15.34 Frank told CRHTT staff that he had read an article that had reminded him of an incident that happened in 2020 when he had assaulted his then partner. Since reading the article he had been feeling remorse and guilt about the incident. He denied that he had harmed anyone since this time and denied having any thoughts to harm himself or others at this time. Frank denied experiencing any low mood or anxiety when asked.

15.35 Staff suggested that Frank may benefit from counselling about this past incident and the feelings that it has raised for him. He was signposted to Let's Talk service and given their contact details. (Let's Talk is an open access primary care service for mild to moderate anxiety and depression related conditions). It was noted that he would consider this. He was encouraged to call CRHTT back should he require further support. Frank reported he was staying with his girlfriend that evening.

15.36 March 2022 the next note on file is from the CJLS, noting that Frank had been arrested at 10:35 hours in March 2022. The custody suite had asked for Frank to be seen by the CJLS as a result of having visible self-injurious marks and query some form of thought disorder.

15.37 It is noted on the assessment by CJLS that Frank was co-operative throughout and maintained good eye contact. He was able to articulate himself and was deemed to have capacity in relation to his arrest for the offence of murder. It is noted he showed good insight into his situation at the time and reported feeling shame.

15.38 It is documented that he did not exhibit any perceptual abnormalities but stated he heard voices. When this was further explored, Frank reported that this was his thoughts, urges and beliefs of his own and of other people's, it is noted that he stated, "it was probably the devil".

15.39 Frank also reported feeling lost with his identity and feeling cold and numb. He reported he "cannot tolerate talking to others". It is noted that Frank reported experiencing fleeting suicidal thoughts but stated he had never attempted suicide prior to an attempted stabbing in his own neck and wrist and referred to jumping in front of a train.

15.40 His risk of suicide was assessed as low, however, in light of the offence type and his disclosure of attempted self-injury and suicidal thoughts, this may have been an underestimation.

15.41 The assessment concluded that no further intervention was required at the time in relation to his mental health and that he was fit to be processed through the Criminal Justice System.

Overview of Involvement with South Western Ambulance Service Foundation Trust (SWASFT)

15.42 999 call was received in March 2022 at 09:17 from the victim's mother. There were no obvious signs of life. As the death appeared suspicious, the crew withdrew from the scene and Police were contacted. SWASFT had no previous contact with the victim.

Overview of Involvement with ICB (On behalf of G.P)

15.43 Michelle had numerous physical health issues including Behcet's disease and Rheumatoid arthritis so visited her GP regularly. No disclosures were made or documented regarding domestic abuse or issues within the family.

15.44 Frank had routine G.P appointments as would be expected, however Frank had two G.P appointments in May and June of 2019 that he did attend with his Mother. The first appointment in May was relating to Frank experiencing anxiety and panic attacks following smoking cannabis and drinking energy/caffeine drinks. Frank had contacted "Childline" for advice. The second appointment in June was a follow up visit to ensure things had settled down, which it appeared they had.

15.45 20th May 2021 Frank attended with his girlfriend. He presented with a three-week history of jaw pain. Frank was referred to oral surgeons.

15.46 9th of March 2022 Frank was seen in clinic to discuss his results and placed on a waiting list for a jaw manipulation procedure.

Overview of Involvement with Gloucestershire Children's Social Care (CSC)

15.47 Michelle was referred to CSC by police following the domestic abuse incident in the family home in July 2013. There were no concerns about Michelle's parenting of the children and therefore the case was closed.

15.48 Another referral was made on 5th July 2013 regarding abuse by Michelle's estranged husband and a concern was raised about an individual who might have had access to the children, but Michelle was considered to be protective of the children, and the case was closed.

15.49 There was no further contact with CSC.

16. Analysis

16.1 The analysis will address the terms of reference and the key lines of enquiry within them. In doing so it will examine how and why events occurred, information that was shared, the decisions that were made, and the actions that were taken or not taken. It will consider

whether different decisions or actions may have led to a different course of events. It will also highlight examples of good practice.

Frank and mental health concerns

16.2 There was no contact with Frank to assess his mental health as a child as he was not open to CSC.

16.3 Frank had a custody risk assessment in October 2020, and no mental health issues were raised or actioned, even though the partner of Frank disclosed concerns.

16.4 A VIST containing this information was submitted to the MASH to review as Medium risk.

16.5 Frank accessed support himself for his mental wellbeing on the 14th of March 2022 when he contacted the police and then CRHTT.

Domestic Abuse: Recognition and Response

16.6 Agencies recognised when Michelle had experienced Domestic Abuse in 2013 by her estranged husband and did offer help through GDASS.

16.7 There is no record of a crime of stalking/harassment recorded when it appears one should have been raised. However, due to major improvements in the national crime recording standard (NCRS), a crime would be raised in relation to this incident if it were reported today. It would also have provided a more detailed record to review. Since 2017 the Constabulary have had a stalking clinic in place and training has been provided to help them identify these behaviours. The response to DA has changed considerably since 2013.

16.8 In 2013 Michelle could have been given the opportunity to provide more detail about the "mental abuse" she states she suffered during their relationship in the event this amounted to any criminal offences. Controlling or Coercive Behaviour was not a crime in 2013 however

harassment within an intimate relationship was. This shows a lack of professional curiosity at the time.

16.9 There was limited recognition in 2013 in reality about the harm caused to both children experiencing domestic abuse in their family home so the decision for no further action at that time was appropriate and proportionate from CSC as Michelle was caring well for the children and they had moved away from the perpetrator of domestic abuse.

16.10 In relation to Frank and concerns for DA; these relate specifically to his girlfriend and not his mother. GHC noted for future practice consideration that CJLS staff could have offered Frank intervention from the local service "Fear Free" as an option to break the cycle when Frank was arrested for a domestic abuse related offence in 2020.However at the time the service would not have accepted someone of Frank's age.

Access to Services

16.11 There is no evidence that Michelle or her family and friends experienced any barriers to engaging with any of the services discussed in this report. On one occasion Michelle referred herself for support and Michelle's Mother contacted the Police about the domestic abuse in 2013.

16.12 Michelle was proactive in seeking support from her GP surgery regarding her physical problems and appropriate referrals were always made. There are no disclosures made about mental health or domestic abuse issues to her GP.

16.13 Although there is no evidence other than the tragic murder of Michelle that Frank was abusive or violent to his Mother it is worth noting that research on Child on Parent Violence (CPV) conducted by Reducing the Risk of Domestic Abuse states that most abused parents' have difficulty admitting even to themselves that their child is abusive. They feel ashamed, disappointed, and humiliated and blame themselves for the situation, which has led to this imbalance of power. There is also an element of denial where parents convince themselves that their child's behaviour is part of normal adolescent conduct.

16.14 Frank's partner didn't want to support any possible charge by the police or to engage with GDASS. This isn't unusual especially at the infancy of an abusive relationship.

16.15 No family member was notified about Frank's call to the Police or to CRHTT as in line with their procedures and protocols. CRHTT can breach confidentiality if they have clear rationale to do so and gain consent to share information. Frank was not asked if he would like any member of his family that he lived with to be informed about his mental health or dangerous thoughts and this is something that was possible if he had been asked and given his consent.

Agency response

16.16 Although it appeared to be the first incident like this in the relationship between Frank and his girlfriend when he physically assaulted her; when she stated "Tonight, he flipped and started talking about ripping people's faces off. He has problems with mental health and alcohol. He can get angry when other guys flirt with me". This could have been investigated further and seems to suggest a lack of professional curiosity.

16.17 When Police asked the question - Has he ever threatened or attempted suicide before? "Yes – he wanted to drink enough to kill himself as life wasn't fun anymore and life wasn't worth living. Earlier tonight he had a kitchen knife in his car and was chopping stuffed animals heads off". These responses in the context of domestic abuse are alarming and more weight could have been given to them. A VIST was created and sent to GDASS, and it is acknowledged that the victim did not want to engage more with GDASS. However, the Police lacked professional curiosity regarding the context and thus the appropriate logging of such disclosures regarding the mutilation he was engaging in with the kitchen knife.

16.18 The police should have inspected Frank's car for the knife considering he was already in police custody and could have been further arrested on suspicion of being in possession of a bladed article in a public place (case law for vehicles).

16.19 No warning marker was added to Frank's police record following the disclosure from the Victim that he had a kitchen knife in his car and had been beheading stuffed animals. This

has not been identified as intelligence by the Officer completing the VIST or the Supervising Officer (Sgt) who reviewed and submitted the VIST.

16.20 Agencies are hindered when records have information missing and when they are not shared between agencies.

16.21 The decision making in the MASH in relation to domestic abuse, referral to support from domestic abuse agencies was appropriate.

16.22 The Police did evidence good practice by contacting CRHTT and reporting that Frank had called them and was concerned by his thoughts – that he might harm others. It is noted that he had made statements to harm others on three occasions whilst on the phone (details not specified in GHC clinical notes, however GHC notes were written on information shared by the police).

16.23 CRHTT noted the call was made to the Crisis line by Frank and he had not been thorough a comprehensive assessment coupled with the fact Frank had no previous contact with MH services. Frank called the CRHTT as he was instructed to by the Police Call Handler. Frank was adamant he didn't want to harm anyone and reached out for help to prevent such harm. Frank had mentioned his thoughts about killing people to the Police Call Handler that evening, but he did not mention this to the CRHTT. It is important to note that Frank's tone of voice in both calls was calm and collected and his language was considered. Frank spoke quietly often throughout the calls, so it was difficult at times to hear him clearly. Frank talked about his future work aspirations and seemed to have a positive outlook for his future.

16.24 The lack of professional curiosity when Frank denied any intent to harm others whilst at the same time reporting thoughts to harm others is an area for learning. The fact that Frank reached out for help with his mental health and had never done so before should not minimise the risk. Frank called the Police initially as he was concerned, he would harm / kill someone.

16.25 CRHTT could have asked more questions of Frank about his girlfriend and domestic abuse towards her or anyone else considering his history in his previous relationship and the

context of the call, when Frank said he was going to be staying with his current girlfriend that evening. Frank does mention that he "enjoyed it at the time" when speaking about his previous DA incident with his Ex-girlfriend and this was not picked up on by the Call Handler. This suggests a lack of professional curiosity regarding Frank's statement. At times the Call Handler didn't let him speak freely enough; almost talking over him. This suggests there is an area for learning regarding hearing and listening.

16.26 This situation highlights a potential lack of accurate record keeping or access to such information between agencies. As this information was not marked as high risk it was not shared between agencies. This can dilute the reality of situations. Relevant information was there as it was disclosed in 2020 by his partner about his mental health issues and wanting to "kill by ripping their faces off" as discussed earlier in the report at paragraph 14.16.

16.27 GDASS showed good practice in 2020 calling and then emailing Frank's girlfriend to try to get her to engage with them.

16.28 GDASS are co-located within the MASH team. MASH replaced the Domestic Abuse Recovery Programme in 2014.

16.29 There are examples of good information sharing between agencies. Whenever the police engaged with Michelle or Frank, and it was appropriate they shared the information with GDASS and CSC.

16.30 There are instances of a lack of triangulation of information, and information being taken at face value which had been shared by Frank. His feelings of remorse seemed to contribute towards a confirmation bias that he wasn't a high risk to others if he was reflecting and saying he felt remorseful.

16.31 No information was shared with Frank's family regarding the disclosures made in 2020 or the telephone call to Police and CRHTT on the 14th of March 2022.
There would, of course be issues of confidentiality and consent but there are no records of consent being sought from Frank to liaise and share with his family members. However, Frank might not have given his consent even if it was asked of him.

16.32 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. It is noted his Mother, Michelle collected him from Custody to take him home. There would be no requirement for the Custody Sgt to have provided any further support or referrals as there had been no information provided to them that this was necessary.

16.33 E-VIST was introduced to assist with the problem of delayed uploading of green VISTS. The delayed uploading does delay any sharing with appropriate partner agencies. Indicators of risk were identified to the MASH.

17. Conclusions

17.1 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.

17.2 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.

17.3 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.

17.4 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.

18. Lessons Identified

18.1 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.

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

18.3 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.

18.4 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.

18.5 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.

18.6 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.

18.7 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.

18.8 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.

18.9 On the night of the 14th of March 2022 CRHTT Call Handler had the notes and knew of 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. 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. If the crisis team are not picking up on such disclosures it is concerning. It has been taken into consideration that the team are mental health nurses and not psychiatrists, however, they should know enough to know when it is more than poor mental health they are confronted with. They also have access to a psychiatrist so could have used that resource. Considering the comments disclosed by Frank the CRHTT could have asked about these comments and called the Police Call Handler to share the new disclosures as they were not mentioned by Frank in his previous call. It 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. 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.

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

18.11 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.

18.12 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.

19. Recommendations

19.1 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.

19.2 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.

19.3 For the Police to fully record and log as intelligence any safe guarding or mental health disclosures and 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).

19.4 Training need for Gloucestershire Health and Care (GHC) -regarding domestic abuse as currently the training for domestic abuse is not mandatory within the CRHTT

department. I recommend it is made 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.

19.5 GHC to actively use the information they are given by other agencies, in this situation the Police. The police did disclose their concerns to the CRHTT, but Frank was not pressed on any of that information when he then called them himself. A recommendation for the CRHTT to have active listening skills training to allow best practice for the department and their service users.

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

Appendix One

Glossary of Terms

Individual Management Review (IMR)

Advocacy After Fatal Domestic Abuse (AAFDA)

Approved Mental Health Professional (AMHP)

Domestic Abuse, Stalking, Harassment and Honour based violence Assessment Tool (DASH)

Vulnerability identification Screening Tool (ViST)

Drug Abuse Screening Test (DAST)

Non - Catalogue Requests (NCRS)

Multi-Agency Safeguarding Hub (MASH)

Data Action Response Plan (DARP)

Officer in the case (OIC)

DHR Michelle Action Plan

Recommendation	Scope of recommendation i.e. local or regional	Action to take	Lead Agency	Key milestones in enacting the recommendation	Target Date	Date of Completion and Outcome	RAG Rating
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.	Local	-Research into CPA best practice -Research into current local response -Report to be taken to DA LPB -Decision making on next steps by DA LPB	DA LPB	As per 'Action to take'	September 2024	*Research into CPA best practice and local approaches complete. This has been included in the county strategy 2025-2028 and included in the DA training pathway with funding being explored. CPA training has been funded via the serious violence duty.* *A range of local recommendations on CPA will be taken forward by the DA LPB.*	

DHR Michelle Action Plan

Recommendation	Scope of recommendation i.e. local or regional	Action to take	Lead Agency	Key milestones in enacting the recommendation	Target Date	Date of Completion and Outcome	RAG Rating
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 witness domestic abuse in the home.	Local	-CYP Needs Assessment recommendation approved by DA LPB -Discussion with commissioning to agree next steps -embed actions into new county strategy and delivery plan	DA LPB	As per 'Action to take'	September 2024 with ongoing action	*All recommendations from the CYP needs assessment have been accepted by the partnership and are being taken forward. This has also been embedded in to the county DA strategy for 2025-2028. A CYP subgroup of the DA LPB is being created to lead on this work.*	
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	Local	Learning and development to be asked to remind all officers in training the	Police	As per 'Action to take'	March 2025 and ongoing	*Action to be overseen by constabulary monthly DA Steering Group*	

DHR Michelle Action Plan

Recommendation	Scope of recommendation i.e. local or regional	Action to take	Lead Agency	Key milestones in enacting the recommendation	Target Date	Date of Completion and Outcome	RAG Rating
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).		importance of recording mental health disclosures using the VIST system alerting other agencies of identified risks,					
The Police to have a DA exit strategy from custody – liaison with services for Signposting relevant services already available in the area.	Local	C/INSP CJD to be approached to consider a review of pre-arranged custody procedures and exit strategies.	Police	As per 'Action to take'	March 2025 and ongoing	*Action to be overseen by constabulary monthly DA Steering Group*	
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	Local	Gloucestershire Health and Care: Domestic abuse specific training (including competition of DASH,	GHC	Delivery of training sessions	March 2025	*DA training is offered across mental health teams by MHIDVA's but there has been an inherent gap due*	

DHR Michelle Action Plan

Recommendation	Scope of recommendation i.e. local or regional	Action to take	Lead Agency	Key milestones in enacting the recommendation	Target Date	Date of Completion and Outcome	RAG Rating
full potential. The department does have twenty-four-hour access to a psychiatrist so an area of learning to engage that resource.		MARAC and GDASS services) to be delivered by MHIDVA's for GHC's Crisis Teams Named Nurse Adult Safeguarding has met with colleagues at GDASS who are able to build and deliver bespoke training for CRHTT over the coming quarter (we can extend this if necessary). GDASS Health Team Leader will be taking this				*to recruitment challenges.* *Staff have recently been appointed by GDASS to the MHIDVA post.* *Training has been developed and is ready for implementation. A meeting was arranged with CRHTT, Service Manager 29.01.25 to discuss rolling out the training plan.* *The logistics of getting 90+ staff*	

DHR Michelle Action Plan

Recommendation	Scope of recommendation i.e. local or regional	Action to take	Lead Agency	Key milestones in enacting the recommendation	Target Date	Date of Completion and Outcome	RAG Rating
		forward in terms of how we can engage CRHHT with the training plan.				*trained is now in place.*	
MHIDVA's to train domestic abuse champions across mental health services.	Local	MHIDVAs to offer training to champions and ongoing support through the established champions network	GHC	Delivery of training sessions	Ongoing as part of MHIDVA role	*DA training is offered across mental health teams by MHIDVA's but there has been an inherent gap due to recruitment challenges.* *Staff have recently been appointed by GDASS to the MHIDVA post.*	

DHR Michelle Action Plan

Recommendation	Scope of recommendation i.e. local or regional	Action to take	Lead Agency	Key milestones in enacting the recommendation	Target Date	Date of Completion and Outcome	RAG Rating
A recommendation for the CRHTT to have active listening skills training to allow best practice for the department and their service users.	Local	With regards to Listening Skills Training it is completed by every member of staff who work in the Crisis Teams and First Point of Contact Centre - it is on Care to Learn. We ensure every member of staff completes this as Essential for Role.	GHC		October 2024	*All CRHTT staff have undertaken Listening Skills Training.*	