**ADULT A DOMESTIC HOMICIDE REVIEW (DHR): LEARNING BRIEF**

The Royal Borough of Windsor and Maidenhead (RBWM) Community Safety Partnership (CSP) conducted a Domestic Homicide Review (DHR) following the death of Adult A, a resident of RBWM, in 2017.

The purpose of a DHR is to learn lessons and improve future responses to domestic abuse. The Review was chaired by an independent Chair who also authored the report, supported by a panel of representatives from agencies who knew the individuals. The Partnership is grateful for the contribution of Adult A's family.

This learning brief is based on findings from the DHR and is designed to highlight the key areas of learning and practice. It is designed to support professional practice and development in our commitment to improve responses safeguard victims of domestic abuse. It has combined key messages and lessons learnt as identified in the Review to enable you and your teams to reflect and challenge your thinking, with a view to implementing positive change and promoting better outcomes for those affected by domestic abuse. Full details of the report and all the recommendations can be found on the RBWM Domestic Abuse webpages.

**WHAT HAPPENED?**

The victim, Adult A, was a 58-year-old White British woman who lived in RBWM with her two sons. In December 2017, Adult B (one of Adult A's sons of the same address) was located in the street by Police Officers, covered in blood. When taken home, Adult A was found with fatal head injuries. Adult B was arrested on suspicion of murder and detained under the Mental Health Act 1983. Following a 'Trial of Fact' in September 2019, a jury found that Adult B had committed the act of killing his mother and he was sentenced to a hospital order with restrictions.

**WHAT DID THE REVIEW TELL US?**

Adult B was in his 30's and living with his mother and brother at the time of the murder. At a young age, Adult B was diagnosed with Autism and hyperactivity, with his condition being managed with regular medication. He also had difficulties with verbal and non-verbal communication, and challenges with his social skills. As a result, Adult B was assessed as needing support in various areas including managing his own behaviour.

Adult A was a key figure in her son's life. Adult A had little involvement from services in her own right, and although she tended to care for Adult B independently of Services, there was professional involvement including visits to the home or contact with the family involving Police, Abri Housing, Adult Social Care (Community Team for People with Learning Disabilities (CTPLD)), Berkshire Healthcare NHS Foundation Trust, local care homes (in and out of the CSP area), a local day care centre and the GP.

There were several incidents recorded where Adult B had displayed sexualised behaviour which the Review considered. However, it was not clear what support was offered to helping Adult B understand acceptable behaviour or if any support for Adult A was offered.

From conversations with her family, Adult A was described as a dedicated and loving mother. The Review found that she had acted in the role of carer for Adult B and made a number of decisions on his behalf (for example declining/cancelling appointments and assessments). Adult B spent some months in a local care home before being removed by Adult A as she was unhappy with the quality of service. He was later voluntarily admitted to a hospital for people with learning disabilities before being admitted to a residential care home outside the area specialising in supporting people with Autistic Spectrum Disorders (ASD) and learning disabilities. After a period of 4 years, he was removed by Adult A to be brought home. Following a capacity assessment it was agreed Adult B was doing much better at home. Despite Adult B living at home with Adult A, she would not identify herself as a carer nor was she offered a carers assessment in order that she could be offered support for her own emotional state and welfare and being made aware of various support opportunities that may have been available to her.

The Review identified regular incidents of domestic arguments, harassment and threats between family members raising concerns over abuse taking place within the family setting and the impact that had on individual as well as the whole family. Despite police recording a variety of domestic abuse complaints (including assaults, harassment and family disputes), there were no formal police reports recording Adult B as perpetrating abuse towards Adult A and at no time

was he assessed as being a risk of harm to others within the family. Family members, as part of police interviews, recognised Adult B's condition required day to day support and described him as having a bad temper which had recently got worse. He self-harmed by biting and hitting himself and had started throwing things around the home.

**WHAT CAN WE DO NOW?**

The Review acknowledged that over the course of time, local and national guidance and practice has changed. Nonetheless, the Review identified important learning. The following summarises the themes from the findings/recommendations:

**i. Think Family & Carers Assessments**

A Think Family approach helps to understand the unique circumstances of an adult or child, and the strengths and resources within the family to provide for their needs, but also identifies where additional support may be required.

Carers play a key role in the individual's care. However, people providing care will not always identify themselves as carers. They may not be aware of how they can contribute information nor of what support is available to them both in relation to carer's assessments and support services. Agencies need to 'Think Family' to be attuned to identifying hidden carers and ensuring there is a suitable referral and assessment process. *(Recommendation 1).*

**ii. Professional Judgement and Professional Curiosity**

When assessing risk, professionals should also provide an assessment based on professional judgement alongside visible risk. *(Recommendation 2).*

Professional curiosity is where a practitioner explores and understands what is happening within a family or for an individual rather than making assumptions or taking a single source of information and accepting it at face value. Professionals should demonstrate professional curiosity in order to explore and understand the wider family dynamics. It is a combination of looking, listening, asking direct questions, checking out and reflecting on all the information given.

Routine contacts may provide valuable opportunities to identify safeguarding issues. Reports of anti-social behaviour or noise disturbances for example could present a chance to ask about domestic abuse. Tenancy visits such as for maintenance and repair can also provide important opportunities for identifying risk and vulnerability. *(Recommendations 2 and 3).*

**iii. Familial domestic abuse**

It should not be assumed that domestic abuse only takes place between partners/ex partners. Professionals should be aware and alert to the fact that domestic abuse can also take place between family members (familial). *(Recommendation 3).*

**iv. Training**

Agencies should ensure their staff are trained in a number of areas, including professional judgement, professional curiosity, relevant areas of legislation (e.g. The Care Act), subject areas of sexualised behaviour (namely the role of parents and family members in providing boundaries and guidance to support those with Autism Spectrum Condition in understanding what is and is not appropriate behaviour, and processes to be followed when service users demonstrate acts of sexualised behaviour involving breaches of criminal law). *(Recommendations 2, 3, 4, 7).*
Autism and behaviours of concern (challenging behaviours) – Autism West Midlands

**v. Information sharing and record keeping**

Information sharing between agencies is critical to providing effective services to victims of domestic abuse. Frameworks such as the Multi-Agency Risk Management Process, and the MATAC (Multi Agency, Tasking And Coordination) should be in place to provide an active and reactive role, and information sharing pathways be agreed so that cases are referred appropriately on a case by case basis. *(Recommendations 5, 8 & 9).*

Agencies should ensure that record keeping is accurate and relevant, and that standards of accuracy and detail are maintained. *(Recommendation 6).*