LEARNING FROM DOMESTIC ABUSE RELATED DEATH REVIEW

Howard and Margaret 2022

WHAT HAPPENED?

- Howard and Margaret were in their 70s when they were killed by their son Paul at their home address. Paul pleaded guilty on the grounds of diminished responsibility at Sheffield Crown Court and was sentenced to a hospital order without a time limit.
- **WHAT DID THE REVIEW TELL US?**
  Paul was diagnosed with epilepsy at 14 years of age and struggled with this and his mental health from that point onwards, but was fully supported by Howard, Margaret, and his two sisters, Suzie and Leah. He did not live at his parents but sometimes stayed with them when unwell.
- The review identified that there had been previous incidents of domestic abuse within the family setting, between Paul and his sister Suzie, and latterly between Paul and his mum Margaret which had gone unreported to professionals and had not been recognised by the family as domestic abuse at the time. Paul's behaviours had become normalised by the family and accepted as part of who he is and part of his illnesses. Some of the behaviour had been identified as unacceptable but also understandable, considering the effect that his epilepsy had on his quality of life.
- The review has identified a lack of professional curiosity in relation to the caring role of Paul's family who were seen as 'protective factors', but who were not involved in conversations or the development of care plans.
- There is evidence of silo working across some of the health providers, with them concentrating on their own involvement with Paul and not the whole patient journey.
- Information was shared appropriately on some occasions but not at other times e.g. if information was not deemed to be 'high risk'. There were particular issues with sharing information between different organisations.

BEST PRACTICE

- Paul was asked throughout all care episodes with the mental health provider or mental health services about his risk of harm to himself and others. When on one occasion he expressed thoughts of harming a child this was reported to the Safeguarding Hub.
- Paul had a consistent consultant throughout his epilepsy care at the acute hospital trust who offered various treatment options.

LESSONS LEARNED

- Professionals could have been more curious about the caring responsibilities Howard and Margaret had, along with their suitability to be carers and the potential for Adult Family Violence within their relationship with Paul. Identifying individuals as carers and a carer's assessment taking place may have assisted in this case.
- Questions were asked at different points to all the individuals about whether they were experiencing domestic abuse, but the focus appeared to be on intimate partner violence and not Adult Family Violence. There needs to be consideration of how domestic abuse enquiries are conducted, and clarity that this includes adult children, and parents acting as carers.
- Whilst there is no easy solution, especially when someone has mental capacity, the issue of obtaining consent to share information could be given more consideration in relation to people with complex needs, where family members are identified as being 'protective factors'.
- There is evidence from research that people with epilepsy have a higher risk of developing psychosis: eight times more people with epilepsy than people who aren't affected. This is an area that needs to be more widely known amongst health professionals and consideration given to selective and routine domestic abuse enquiries, specifically with carers / family members of individuals diagnosed with epilepsy due to the risks of Adult Family Violence.

WHAT CAN WE DO NOW?

Professionals to consider the appropriateness of informal carers. Support should be offered to those, identified as a "protective factor" where any of the Trilogy of Risk (mental health issues, substance misuse, domestic abuse) is evident.	The Safer Sheffield Partnership will continue campaigns to raise awareness of Adult Family Violence to increase understanding and identification.	Professionals, made aware of any increased risks or concerns for patients on waiting lists, should share and escalate the information so that a review of their place on the waiting list can be considered.	During annual epilepsy reviews, professionals should discuss the impact on others (and the potential for domestic abuse) in the household. Providers to consider the development of a clear pathway for epilepsy patients between trusts.	Health providers to review their approaches to providing personalised care to patients with complex needs, including how information is shared externally.	Agencies should ensure the Sheffield Adult Safeguarding Partnership guidance document on Safeguarding Responsibilities for Partnerships is implemented in their organisation.