PENDLE COMMUNITY SAFETY PARTNERSHIP

DOMESTIC HOMICIDE REVIEW

'Charles'

Died: May 2020

EXECUTIVE SUMMARY

December 2023

Chair and Author: Carol Ellwood-Clarke QPM
Independent support to Chair: Ged McManus

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1. THE REVIEW PROCESS

1.1 This summary outlines the process undertaken by Pendle Community Safety Partnership [the statutory Crime and Disorder Partnership] in reviewing the homicide of Charles a resident in their area.

1.2 The following pseudonyms have been used in this review for the victim, and perpetrator to protect their identities. The pseudonyms were chosen by the family.

Name	Relationship	Age	Ethnicity
Charles	Victim	65	White British male
Bill	Perpetrator	32	White British male

1.3 Charles died following injuries sustained in an assault at his home address. Bill was arrested and charged with Charles's murder.

1.4 In October 2021, Bill pleaded guilty to the manslaughter[1] of Charles on the grounds of diminished responsibility. In December 2021, Bill was sentenced to an indefinite hospital order[2] combined with a life sentence. The Judge QC ruled that if Bill was ever ruled well enough for release from the hospital setting, then he would then have to start a life prison sentence because of the danger he poses to the public. Bill would then have to serve a minimum of 12 years of that life sentence before he would be eligible to go before the Parole Board.

1.5 Pendle Community Safety Partnership met on 10 June 2020 and determined the death of Charles met the criteria for a domestic homicide review [DHR]. The Home Office were informed, and an independent domestic homicide review was commissioned. All agencies that potentially had contact with Charles and Bill prior to the homicide were asked to secure their files.

1.6 The first meeting of the DHR panel was held on 29 October 2020. Thereafter five further meetings were held, and a draft report written. All meetings

[1] https://www.sentencingcouncil.org.uk/offences/crown-court/item/manslaughter-by-reason-of-diminished-responsibility/
A conviction for manslaughter by reason of diminished responsibility necessarily means that the offender's ability to understand the nature of the conduct, form a rational judgment and/or exercise self-control was substantially impaired.

[2] Section 37/41 hospital order with restrictions, this is an "indefinite" order which means that there is no time limit to renew the Section as it continues indefinitely until the person is discharged by the Secretary of State for Justice or the Mental Health Tribunal.

were held online due to restrictions in place because of the Covid-19 pandemic.

1.7 An interim overview report was presented to Pendle Community Safety Partnership on 19 July 2021. The report contained the learning and recommendations that had been identified during the DHR until the suspension in May 2021, due to the criminal investigation. This process was undertaken to prevent any delay to the implementation of the identified learning and recommendations.

1.8 The final overview report was presented to Pendle Community Safety Partnership on 18 July 2022.

1.9 Charles's family were involved in the review process, having access to the report and meeting with the review Chair.

2. CONTRIBUTORS TO THE REVIEW

2.1 The table below shows the agencies that contributed to the review and the material they were able to supply.

Agency	IMR[3]	Chronology	Report
Blackburn with Darwen and East Lancashire Clinical Commissioning Group	✓	✓	
Lancashire Constabulary	✓	✓	
Lancashire County Council – Mental Health	✓	✓	
Lancashire and South Cumbria NHS Foundation Trust	✓	✓	
North West Ambulance Service			✓

2.2 The authors of the Individual Management Reviews included in them a statement of their independence from any operational or management responsibility for the matters under examination.

[3] Individual Management Review: a templated document setting out the agency's involvement with the subjects of the review.

3. THE REVIEW PANEL MEMBERS

3.1 The panel members were:

Name	Job Title	Organisation
Amanda Baille	Service Manager – Mental Health	Lancashire County Council
Claire Bennett	Chief Executive Officer	Be Free (Formerly Pendle Domestic Violence)
Amelia Brummitt	Specialist Safeguarding Practitioner	Blackburn with Darwen and East Lancashire Clinical Commissioning Group
Carol Ellwood-Clarke	Chair and Author	Independent
Garry Fishwick	Review Officer	Lancashire Constabulary
Wayne Forrest	Localities and Policy Manager	Pendle Borough Council
Emma Foster	District Manager	Inspire[4]
Mathew Hamer	Training Development Manager	Lancashire Fire and Rescue Service
Tim Horsley	Community Protection Co-ordinator	Pendle Borough Council
Dr Karen Massey	Named GP for Safeguarding	East Lancashire Clinical Commissioning Group
Ged McManus	Support to Chair and Author	Independent
Anne Oliver	Community Engagement Manager	Age UK Lancashire
Mark Potter	Mental Health Specialist	NHS England
Lesley Riding	Named Nurse Safeguarding Adults	Lancashire and South Cumbria NHS Foundation Trust
Lee Wilson	Detective Chief Inspector	Lancashire Constabulary

[4] https://www.changegrowlive.org/inspire-east-lancashire/burnley?gclid=CjwKCAjwiuuRBhBvEiwAFXKaNMtsrhDvG2pxYRKev9VKYxFPhoNBNz4CE6pXwqCnYZiqflwiQIg1lBoC9IwQAvD_BwE
We offer a wide range of support for anyone worried about their own or somebody else's substance and alcohol use. We offer advice and guidance to individuals and family members from assessment through to treatment and aftercare. The treatment options we offer include one-to-one key working, group work, detox and rehab, housing support and psychological therapies.

3.2 The panel met six times and the review Chair was satisfied that the members were independent and did not have operational and management involvement with the events under scrutiny.

4 CHAIR AND AUTHOR OF THE OVERVIEW REPORT

4.1 Carol Ellwood-Clarke was appointed as the DHR Independent Chair. She is an independent practitioner who has chaired and written previous DHRs and other safeguarding reviews. Carol retired from public service (British policing – not Lancashire) in 2017, after thirty years, during which she gained experience of writing independent management reviews, as well as being a panel member for Domestic Homicide Reviews, Child Serious Case Reviews, and Safeguarding Adults Reviews. In January 2017, she was awarded the Queens Police Medal (QPM) for her policing services to Safeguarding and Family Liaison. In addition, she is an Associate Trainer for SafeLives[5].

4.2 Ged McManus is an independent practitioner who has chaired and written previous DHRs and Safeguarding Adults Reviews. He has experience as an Independent Chair of a Safeguarding Adult Board. He served for over thirty years in different police services in England (not Lancashire). Prior to leaving the police service in 2016, he was a Superintendent with particular responsibility for partnerships including Community Safety Partnership and Safeguarding Boards.

4.3 Between them, they have undertaken the following types of reviews: Child Serious Case Reviews; Safeguarding Adults Reviews; multi-agency public protection arrangements (MAPPA) serious case reviews; Domestic Homicide Reviews; and, have completed the Home Office online training for undertaking DHRs.

4.4 Neither practitioner has worked for any agency providing information to the review.

[5] https://safelives.org.uk/

5 TERMS OF REFERENCE

5.1 These were set as:

The purpose of a DHR is to:[6]

a] Establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims;

b] Identify clearly what those 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;

c] Apply these lessons to service responses including changes to inform national and local policies and procedures as appropriate;

d] Prevent domestic violence and homicide and improve service responses for all domestic violence and abuse victims and their children by developing a co-ordinated multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest opportunity;

e] Contribute to a better understanding of the nature of domestic violence and abuse; and

f] Highlight good practice.

N.B. This DHR is not a review in accordance with the requirements of NHS Serious Incident Framework[7].

Specific Terms

1. What indicators of domestic abuse, including coercive and controlling behaviour, did your agency have that could have identified Charles as a victim of domestic abuse, and what was the response?

[6] Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews [2016] Section 2 Paragraph 7

[7] https://improvement.nhs.uk/resources/serious-incident-framework/

2. What knowledge did your agency have that indicated Bill might be a perpetrator of domestic abuse against Charles, and what was the response?

3. What was your agency's knowledge of any barriers faced by Charles that might have prevented him reporting domestic abuse, and what did it do to overcome them?

4. Did Charles have any known vulnerabilities, and was he in receipt of any services or support for these?

5. What risk assessments did your agency undertake for Charles or Bill; what was the outcome, and if you provided services, were they fit for purpose?

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

7. Did actions or risk management plans fit with the assessment and decisions made?

8. When, and in what way, were the subjects' wishes and feelings ascertained and considered? Were the subjects informed of options/choices to make informed decisions? Were they signposted to other agencies, and how accessible were these services to the subjects?

9. Did the agency have policies and procedures for Domestic Abuse and Safeguarding, and were these followed in this case? Has the review identified any gaps in these policies and procedures?

10. Were there any issues in relation to capacity or resources in your agency that affected its ability to provide services to Charles and Bill, or on your agency's ability to work effectively with other agencies? N.B. Please also consider any additional capacity/resource issues with agency contact during the Covid-19 pandemic.

11. How did your agency take account of any racial, cultural, linguistic, faith or other diversity issues, when completing assessments and providing services to Charles and Bill?

12. What learning has emerged for your agency?

13. Are there any examples of outstanding or innovative practice arising from this case?

14. Does the learning in this review appear in other Domestic Homicide Reviews commissioned by Pendle Community Safety Partnership?

Timescale

5.2 The review covers the period from 1 January 2019 to May 2020 when Charles died. The Review Panel agreed on these dates to capture agency contact within the preceding 18 months prior to the murder of Charles. There had been no significant agency contact with the subjects of the review prior to the commencement date.

6. SUMMARY CHRONOLOGY

6.1 Charles

6.1.1 Charles was the second eldest of his seven siblings. Charles's siblings described a happy childhood with their parents. All of the siblings helped to look after each other and whilst there was not much money to go around, the family took good care of each other. Charles was a much-loved brother to all of his siblings and they miss him very much.

6.1.2 Charles was described as a quiet man who kept himself to himself. He enjoyed a drink and playing darts at his local club. He supported Burnley Football Club avidly and loved walking his dog. He also enjoyed travelling, visiting a friend in Australia regularly: on one occasion, he took his son Bill with him.

6.1.3 Charles met his wife when he was in his 30s. His wife already had two children and the couple went on to have Bill together. When Bill was two or three years old, the couple split up and Charles moved out of the family home. Bill stayed with his mother and her new partner until he was 16, when he moved to live with Charles.

6.1.4 After Charles and Bill's mother separated, Charles had another long-term relationship, but sadly this lady died: Charles remained single after this time. Charles was still working at the time of his murder; he was a caretaker for a local business. Charles had worked for the company for many years and was looking forward to retirement. Following his murder, his work employees raised money for a plaque to be displayed at Burnley's football ground, Turf Moor.

6.2 Bill

6.2.1 Bill was Charles's only child. Bill did not find employment until he was around 23 years old. Whilst Charles was a private man who didn't share many details, his family were aware that he supported Bill significantly. For example, paying for him to go to football, buying his cigarettes, and paying for him to visit Australia. When Bill did find work, it was generally part-

time – he worked in a large retail store, a food factory and, latterly, a leisure centre as a cleaner. Bill informed the Chair that prior to the Covid-19 pandemic, he had been working part-time as a cleaner: a role he had undertaken for about one year. Bill stated that when he was not working, he spent his time at home, looking at the internet.

6.2.2 The family observed that the relationship between Charles and Bill was good. They attended family gatherings together and everyone appeared to get on. Charles's family stated that he was very protective about Bill and would not hear a bad word said against him.

6.3 Events pre-Terms of Reference

6.3.1 In 2003, at the age of 15, Bill was seen by his GP. During the appointment, Bill admitted to using cannabis for 6-12 months as a means to calm himself down. There were reported episodes of self-harm: the first, in 2011, when he had tied a belt around his neck; and, a further incident where he held a knife to his throat.

6.3.2 Bill was referred to Psychiatry, who referred him for bereavement counselling. Bill was prescribed antidepressants but his compliance with the medication was limited. Bill was discharged from Healthy Minds as he failed to attend appointments. No information was held by Healthy Minds to inform the review.

6.3.3 In 2016, Bill presented to his GP on three occasions with low mood. Bill reported to be struggling at home, with concerns that Charles was developing dementia. Bill was signposted to self-refer to Improving Access to Psychological Therapies[8]; however, he did not self-refer. Bill reported an improvement with his mood due to the medication, and that he was receiving support from his family.

6.3.4 In 2016, Bill was arrested for an assault. The victim was a passenger on a bus. The crime was dealt with by way of restorative justice[9].

[8] https://eastlancsccg.nhs.uk/patient-information/your-health/mental-health/iapt-services
[9] https://restorativejustice.org.uk/what-restorative-justice
Restorative justice brings those harmed by crime or conflict and those responsible for the harm into communication, enabling everyone affected by a particular incident to play a part in repairing the harm and finding a positive way forward. This is part of a wider field called restorative practice.

6.3.5 Charles's family told the Chair that approximately 2-3 years prior to his murder, Bill had assaulted his step-father. The police confirmed that Bill's step-father reported an assault around this time; however, the perpetrator was not identified, and the crime was recorded as undetected. Bill's mother confirmed to the Chair that it had been Bill who had physically assaulted her partner; however, her partner did not provide his details to the police.

6.3.6 Bill told the Chair that he had assaulted his step-father, and that this was in response to witnessing his step-father assaulting his mother, by pushing her over.

Events during the timescales of the review

6.4 2019

6.4.1 In January, Charles attended hospital with a facial injury which was recorded as a 'fall injury to head'. Charles left hospital before he received treatment. Charles had been reported missing to the police by a family member. Two days later, Bill telephoned the police and reported that Charles's injuries were due to an assault. The perpetrator/s were not identified, and the crime was recorded as undetected.

6.4.2 The family told the Chair that they were very suspicious of the circumstances of the assault that Charles reported in January. Bill had telephoned one of the siblings to say Charles was missing and then said that he had been mugged, even before he had been found. After this incident, Charles kept his family at a distance for a while. When one of them saw him a few weeks later, still with extensive bruising on his face, he wouldn't say what had happened and just said: "I don't want any fuss".

6.4.3 Prior to the incident in January, Charles had been in the habit of ringing his brother every Sunday evening when he returned home from having a drink at his club, at 9 pm. After this, he stopped calling for a while and when he did call, the family stated that Charles did not say very much. The family told the Chair that, on reflection, his family wondered now if he was being guarded about what he said because Bill might have been listening.

6.4.4 At the end of January, Charles was seen by a GP and reported that he was struggling with memory and headaches from the assault. Charles was

referred for a CT scan and issued with a fit note[10]. After several failed attempts to contact Charles by the GP surgery, he was eventually seen by a GP at the beginning of April, when he received the results of the CT scan.

6.4.5 In June, Bill attended at hospital with a back injury. In August, Bill attended at hospital again with facial injuries sustained during an assault. The matter was not reported to the police, and the perpetrator was not known.

6.5 2020

6.5.1 At the end of January, Bill was seen by a GP with reported concerns of cannabis and cocaine use. Bill stated that he had used cannabis since the age of 12 and had recently started to use cocaine (2-3 bags a day), as well as smoking 20 cigarettes a day. Bill admitted that he had previously had support with his mental health but did not attend follow-up appointments. The GP advised Bill that he needed specialist input from Inspire.

6.5.2 Charles's brother told the Chair that he had been to visit him, prior to his birthday at the beginning of April, and had not been allowed in the house by Bill, which at the time they thought was 'odd'.

6.5.3 On 9 April, Charles and Bill went to a police station. Charles reported that he had been assaulted by Bill, who had slapped him about the head and repeatedly punched him. Charles stated that he had fled the house in the attack and had gone to his ex-wife's home. Charles stated that Bill was suffering with mental health problems. Bill was sat outside the police station but would not engage with officers. Charles stated that Bill was in possession of a rope and had insinuated that he was going to kill himself. Charles declined to make a formal complaint of assault. Bill ran away from the officers towards the railway lines. The officers followed Bill and he was detained under Section 136 Mental Health Act 1983. Bill was taken to a mental health suite at a hospital. Officers submitted a high-risk Vulnerable Adult Police Safeguarding Report for Bill, and a crime report for common assault on Charles. The assault was not investigated further. The Vulnerable Adult Police Safeguarding Report was received in the MASH on 12 May 2020.

6.5.4 On arrival at the suite, Bill tested positive for cocaine and cannabis use on a drug screening test. A Mental Health Act (MHA) assessment was

[10] https://www.gov.uk/government/collections/fit-note

completed with a plan for informal admission into hospital for mental health assessment and support. Bill resisted the informal admission and absconded from the ambulance, which resulted in the police returning Bill to the mental health suite. A further assessment was undertaken, and it was approved under Section 13 Mental Health Act 1983, for an application for detention under Section 2 Mental Health Act 1983. Bill was admitted to hospital.

6.5.5 On 11 April, a clinical entry was made that stated a safeguarding referral may be required due to the violence and aggression towards Charles prior to Bill's admission. A safeguarding referral was not made.

6.5.6 On 14 April, during an assessment, Bill was asked about the assault on his father. Following the assessment, it was decided to arrange a Care Programme Approach (CPA)[11] review – for Bill to self-refer to Inspire and for a review of his Mental Health Act status. Contact was to be made with Charles to ascertain if Bill was able to return to the address.

6.5.7 The following day, the CPA was completed with the following management plan recommended:

- Commence medication, Sertraline 50mg
- Escorted Section 17 grounds leave with staff
- Nursing staff to contact Charles for collateral history and establish whether Bill can stay with Charles once he is discharged from hospital at some point
- Review next week for discharge.

Contact was made with Charles, who agreed for Bill to return to the house.

6.5.8 On 20 April, Bill was discharged. A 48-hour follow-up was arranged with Pennine East Crisis team for the following day. A discharge letter was sent to the GP surgery (by post). Bill was issued with two weeks' worth of medication. Bill attended the following day with Charles. During the appointment, Bill reported an interest in Talking Therapies[12], and he was provided with the self-referral form for Minds Matter[13]. Bill was also given

[11] https://www.nhs.uk/conditions/social-care-and-support-guide/help-from-social-services-and-charities/care-for-people-with-mental-health-problems-care-programme-approach/
The Care Programme Approach (CPA) is a package of care for people with mental health problems.
[12] https://eastlancsccg.nhs.uk/patient-information/your-health/mental-health/iapt-services
[13] https://www.lscft.nhs.uk/Mindsmatter

information on how to access third sector agencies, including contact details of local drug and alcohol services. As the 48-hour follow-up was during the Covid-19 pandemic, phone numbers for the relevant agencies were provided verbally, to enter into the patient's phone or to write down, as leaflets/cards were seen as an infection risk at that time.

6.5.9 On 22 April 2020, following a review of Bill's case, he was discharged from the Home Treatment Team back to the care of the GP. On 30 April, the GP surgery made two attempts to contact Bill to review his medication. These were unsuccessful.

The following information was gathered during the criminal investigation.

6.5.10 On 8 May, Charles encountered a family member in a shop. Charles stated that Bill was "preoccupied with the Covid-19 virus" and had been researching this on the internet. The family member works within a local mental health trust and provided Charles with her phone number in case he wanted to call her for advice.

6.5.11 In the week prior to his murder, Charles visited his former wife several times and reported that their son, Bill, had been acting strangely. Charles was noted to be frightened of returning home. Charles told his former wife that he intended to tell Bill to leave their home at the end of the month. Bill was told by his mother that Charles was going to ask him to leave the property.

6.5.12 The criminal investigation was also informed that Charles had attempted to contact Bill's GP but was unable to do so as the doctor was on holiday.

6.5.13 On the morning of 20 May, Charles called the family member, who he had seen on 8 May, and told her that he had been up all night with Bill. Charles said that Bill "was paranoid" and had been going to the door all night to check it was locked. The family member was concerned that Charles sounded very tired. The family member made enquiries with colleagues regarding the care of Bill, explaining her personal involvement, and ascertained that Bill had been discharged by the Home Treatment Team back to the care of his GP. The family member enquired about options and contact details, and relayed this back to Charles.

6.5.14 The following day, Charles called the family member again and advised that Bill had stopped taking his medication and had been smoking substances other than tobacco. The family member recalled that Charles sounded much better during this call. Charles was advised to speak with the mental health team. The same day, whilst at work, Charles took a call from Bill and was overhead telling his son to "calm down" and reassuring him that he would sort things out when he returned home. Charles was noted to appear distressed after receiving this call. He told a colleague that his son had mental health problems.

6.5.15 The family told the Chair that they did not know about the assault, which led to Bill's detention under the mental health act, until after Charles murder. The exception to this was the family member who had spoken to Charles in the days before his murder and signposted him to services which might help Bill.

6.5.16 In May 2020, Charles was found deceased. Bill was arrested and charged with the murder of Charles.

7. KEY ISSUES ARISING FROM THE REVIEW

7.1 In the month prior to the murder of Charles, his son, Bill, had been admitted to hospital under Section 2 of the Mental Health Act 1983. This followed an assault on Charles by Bill.

7.2 The review identified that whilst agencies responded to Bill's mental health presentation, they did not take account or recognise that the assault on Charles was domestic abuse. Professionals did not discuss the assault and domestic abuse with Charles. Charles was not referred into domestic abuse services, or other agencies, and therefore was not provided with opportunities to seek support.

7.3 Bill was never spoken to by the Police in relation to the assault he had perpetrated on Charles. The risk that Bill presented to Charles was never assessed.

7.4 Discussions around the discharge of Bill, were undertaken in the presence of Charles. At no time was Charles spoken to on his own, to allow his views on Bill returning to the home to be heard.

7.5 The Review Panel identified that Charles's age, gender and relationship with Bill were not recognised by Professionals within the definition of domestic abuse.

7.6 Charles did not have access to information upon where he good seek support, in relation to the domestic abuse, and Bill's mental health and drug use. The Review Panel identified that there was a reliance by Professionals that individuals are able to gain access to information through the use of the internet; however this was not available to Charles as he did not have the means to, or know how to access the internet. This was never established during Charles's engagement with Professionals.

8. CONCLUSIONS

8.1 Charles was murdered by his son, Bill. Charles had worked for all his adult life, and his family told the Chair that at the time of his murder, he was in the final stages of looking forward to his retirement.

8.2 In the month prior to the murder, Bill had assaulted Charles, and been admitted to hospital under Section 2 Mental Health Act 1983. The Review Panel was clear that this assault was domestic abuse. Whilst agencies recorded that Bill had assaulted Charles, it was not recognised as domestic abuse, and therefore Charles was not signposted to services for support. The assault was not investigated as a criminal offence.

8.3 Whilst detained in hospital, Bill was reluctant to discuss the assault with health professionals, and his decision not to talk about the event was accepted and not challenged. Therefore, the extent of this incident was not fully understood by professionals.

8.4 The decision to discharge Bill back home to live with Charles was made without any consideration of the risk that Bill posed to Charles. Whilst Charles had been involved in some discussions on Bill returning to the family home, these discussions took place in the presence and hearing of Bill: they did not provide Charles with an opportunity to speak privately and raise any concerns on this decision, or allow him to disclose domestic abuse. The Review Panel was clear in their analysis that it was not appropriate to speak to a victim of domestic abuse in the presence and hearing of a perpetrator.

8.5 The Review Panel has identified several areas of learning in relation to the recognition of domestic abuse in older male victims, in particular where the perpetrator is a child of the victim. Further areas of learning include the accessibility to information for individuals who are concerned regarding a person's mental health, and the impact of the use of illicit drugs on a person's mental health.

8.6 Charles's family contributed invaluably to the review: by providing information, meeting with the Chair, and reviewing a draft version of the report. The Review Panel wish to extend their thanks to the family for this contribution.

9. LEARNING

9.1 The DHR panel identified the following learning. Each point is preceded by a narrative which seeks to set the context within which the learning sits. Where learning leads to an action a cross reference is included within the header.

Learning 1 [Panel recommendation 1]
Narrative
Blackburn with Darwen and East Lancashire Clinical Commissioning has identified learning from previous DHRs in relation to the recording and use of 'routine enquiry', and created a template within electronic systems. This has been identified by the DHR panel as good practice.
Lesson
Talking about domestic abuse during routine health appointments provides victims of domestic abuse an opportunity to share any concerns, and gives professionals the opportunity to refer and signpost victims to support services.

Learning 2 [Panel recommendation 2]
Narrative
Domestic abuse can be presented in many ways, including being hidden or masked by other critical circumstances. Professionals need to ensure that when engaging with individuals at crisis point, they consider the wider context and impact on all who are affected by the situation, to identify cases of domestic abuse.
Lesson
By identifying incidents as domestic abuse, it allows for professionals to complete a risk assessment, and to determine the level of risk and requirement for agency involvement, including referral and signposting to services.

Learning 3 [Panel recommendation 3]
Narrative

People's presentation at a point of crisis may be linked to other factors in their life, which require support from other agencies. Professionals need to be able to recognise these incidents and ensure that relevant referrals are completed.
Lesson
Understanding the circumstances surrounding incidents when individuals are presenting at a time of crisis, will enable appropriate referrals and signposting to agencies to be undertaken.

Learning 4 [Panel recommendation 4]
Narrative
The use of illicit drugs can trigger mental health problems or make existing mental health problems worse.
Lesson
Information on the effects of illicit drug use, and the impact that this could have on an individual's mental health, should be accessible to practitioners and the community.

Learning 5 [Panel recommendation 6]
Narrative
The review identified that agencies should not just rely on individuals accessing information via the internet: information should be available in a variety of formats so that it is accessible to all members of the community.
Lesson
All members of the community should be able to access information, in a range of formats, to allow them to gather information on the availability of agencies and support services that can respond to concerns regarding an individual's mental health.

9.2 Agencies learning

9.2.1 Blackburn with Darwen and East Lancashire Clinical Commissioning Group

- Learning around the wider context of domestic abuse in relation to familial domestic abuse.
- The importance of routine enquiry when a patient attends with an alleged assault, even for those that would not be perceived as an at-risk group.

- The importance of using routine enquiry within mental health reviews, both for discussing the victim of domestic abuse, but also the perpetrator.
- Flagging of records if it is raised someone has caring responsibilities, and the consideration of a referral for a carer's assessment.

9.2.2 Lancashire Constabulary

- Identifying victims and perpetrators of domestic abuse who may be presenting with mental health conditions, and ensuring they are referred to relevant support services.
- Recording and risk grading of incidents of vulnerability.

9.2.3 LSCFT

- Where risks are identified through enhanced risk assessment, they should have accompanying actions on the risk management plan.
- Routine enquiry should be completed in all cases where there is identified safeguarding concern around domestic abuse.
- Teams and practitioners should 'think family'. Actions should be clear in response to any identified risk. Where there are concerns or uncertainties, this should be escalated to line manager and discussed within individual and team supervision.
- Risk, health and social needs assessments should be completed through collaboration with service users, family and carers where applicable. When not possible, collateral information should be gathered and used to support risk assessment and management plans.

The Review Panel recognised the importance of Pendle CSP being provided updates in relation to the implementation of the recommendations and learning from LSCFT internal investigation – they have made a relevant recommendation. [Recommendation 5].

9.2.4 Lancashire County Council – Mental Health

- To ensure that AMHPs pass on the case information to community teams for follow up after Mental Health Act assessments, and refer cases for full Care Act and Social Care assessments where necessary.

9.2.5 In addition to individual agency learning, the DHR panel was informed that the following have been added to the Pendle Domestic Abuse action plan:

- Need to ensure the Pendle Domestic Abuse Forum supports the campaign work of Lancashire DA Strategic Board locally. This will include supporting the 'no excuse for abuse' campaign.
- Need to raise awareness to professionals and the community around the issue of domestic abuse within familial settings.
- To identify and work with Age UK (Lancashire) and other identified charities aimed at older people and carers.
- Undertake awareness activities related specifically to this issue, including updating websites as required.

10. RECOMMENDATIONS

10.1 Panel and Agency Recommendations

10.1.1 Panel Recommendations

Number	Recommendation
1	That Blackburn with Darwen and East Lancashire Clinical Commissioning Group provides updates to Pendle Community Safety Partnership on the rollout of the routine enquiry template within GP practices.
2	That all agencies[14] provide reassurances and evidence to Pendle Community Safety Partnership that the learning from this case, in relation to the recognition of domestic abuse including the identification of domestic abuse in males and the older generation, has been disseminated.
3	That Lancashire Constabulary provides an update to Pendle Community Safety Partnership on the action plan and learning from the recent DHR concluded in Blackpool in 2021.
4	That Pendle Community Safety Partnership ensures information is available on the effect and impact of using illicit drugs.
5	That Lancashire and South Cumbria NHS Foundation Trust provides progress updates to Pendle Community Safety Partnership regarding their internal investigation action plan – these will be at 3, 6 and 9 months, with a presentation to the CSP at the 12 months' stage to assure the CSP of progress, and inform of any ongoing challenges.
6	That Pendle Community Safety Partnership ensures that access to information on support services which can respond to concerns regarding an individual's mental health, whether the concerns are in relation to the individual's own mental health or for someone they know, is available for all members of the community.

[14] This will include the Integrated Care Board which is due to replace the CCG in 2022.

10.1.2 Agency Recommendations

Blackburn with Darwen and East Lancashire Clinical Commissioning Group

- Further learning needs to be undertaken around familial domestic abuse and the importance of widening the context of domestic abuse.
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- To raise awareness of familial abuse with GPs
- Routine enquiry needs to be undertaken when a patient attends with an alleged assault to surgery, even for those that would not be perceived as an at risk group.
- The importance of using routine enquiry within mental health reviews for discussing the victim of domestic abuse.
- Flagging of records if it is raised someone has caring responsibilities and the consideration of a referral for a carer's assessment.

Lancashire Constabulary

- Identifying victims and perpetrators of domestic abuse who may be presenting with mental health conditions, and ensuring they are referred to relevant support services.
- Recording and risk grading of incidents of vulnerability.

LSCFT

- Where risks are identified through enhanced risk assessment, they should have accompanying actions on the risk management plan.
- Routine enquiry should be completed in all cases where there is identified safeguarding concern around domestic abuse.
- Teams and practitioners should 'think family'. Actions should be clear in response to any identified risk. Where there are concerns or uncertainties, this should be escalated to line manager and discussed within individual and team supervision.
- Risk, health and social needs assessments should be completed through collaboration with service users, family and carers where applicable. When not possible, collateral information should be gathered and used to support risk assessment and management plans.

Lancashire County Council – Mental Health

- To ensure that AMHPs pass on the case information to community teams for follow up after Mental Health Act assessments, and refer cases for full Care Act and Social Care assessments where necessary.