Domestic Homicide Review using the Adult Practice Review (DH-APR) (pilot 2) GWASB 1.2020
'Sean'

Brief outline of circumstances resulting in the Review

1. Legal Context

In 2011 Domestic Homicide Reviews (DHRs) were established on a statutory basis under section 9 of the Domestic Violence, Crime and Victims Act (2004). A "domestic homicide review" is now required in circumstances where the death of a person aged 16 or over has, or appears to have, resulted from violence abuse or neglect by:

(a) a person to whom he was related or with whom he was or had been in an intimate personal relationship, or
(b) a member of the same household as himself.

Overall responsibility for establishing a review rests with the local Community Safety Partnership (CSP) or Public Service Boards (PSBs) and will establish a multi-agency review Panel to undertake the review. Reviews are held with a view to identifying the lessons to be learnt from the death.

In October 2017, Assistant Chief Constable Liane James commenced a secondment to Welsh Government to undertake work on the Violence Against Women Domestic Abuse and Sexual Violence agenda. A particular focus was to look to: "Assess the effectiveness of the Welsh Government, Community Safety Partnership and other public services response to Domestic Homicide Reviews and make recommendations as to how they might be fully acted upon by Welsh public services". This work had been informed by Robinson et al. (2018) Findings from a thematic analysis of reviews into adult deaths in Wales: Domestic Homicide Reviews, Adult Practice Reviews and Mental Health Homicide Reviews. Cardiff University, available at http://orca.cf.ac.uk/111010

This DHR was conducted using the Adult Practice Review (APR) methodology. This was the third Pilot in agreement with the Home Office, Torfaen PSB, Gwent Safeguarding Board and the Welsh Government.

The Police referred the case to the Community Safety Partnership/Public Service Board (CSP/PSB) who agreed that this case met the criteria for a Domestic Homicide Review and agreed for the referral to the Gwent Safeguarding Board Case Review meeting for consideration.

The Case Review Group – (a sub-group under the auspices of the Gwent Safeguarding Board) accepted the DHR referral on 11/02/2020 with agreement to use the DH-APR pilot methodology, and appointment of the Chair and reviewers was established. At this point criminal proceedings had not concluded. The first panel meeting was held on 01/06/2020 and established the time line and panel membership.

Torfaen Public Services Board (PSB) panel member would conduct all communication with the Home Office and update Torfaen PSB of progress with the review.

The inclusion of Sean's family members was crucial to the review and they met with the reviewers and had email contact through the review process. At the time the Covid pandemic was impacting face to face meetings, however the initial meeting with the family was in person at their request.

Sean's long-term partner chose not to be part of the review.

Adult A's ex- partner decided not to be part of the process, we also explored the children both biological and stepchildren to Adult A and were informed they did not want to be part due to grief over their grandad. At the end of the process Adult B, the ex-partner of Adult A contacted one of the reviewers and had a lengthy discussion. This was after her adult daughter had died, and in remembrance of her she wanted the impact of Adult A as her stepfather included in the review. Adult A also contributed to the review and permitted a visit to prison.

Sean or Adult A. had very little contact with services besides their General Practitioner.

The family agreed to meet with the reviewers and were offered and supported by a family liaison officer, independent advocacy was also offered but declined at the point of meeting with the reviewers. The family were informed that independent advocacy would be available at any point of the review if they changed their mind. We also explored the wider family and friends that may want to be part of the review, particularly Sean's long-term partner. The family agreed to discuss and inform the reviewers if others wanted to be included or had anything to add to the review.

The family chose the pseudonym for Sean as it meant something personal to them and the wider family.

2. Circumstances resulting in the Review

This DH-APR concerns a father who was killed by his adult son. For the purposes of the report the victim, father will be referred to as Sean and his son the perpetrator as Adult A.

Adult A moved into his father's home after the break-up of his long-term relationship with Adult B, briefly staying in a hotel before he moved back into his father's home. He lived there until September 2019 until the day he fatally assaulted his father, Sean.

Adult A was sentenced to a life sentence of 13 years and 4 months in August 2020.

Sean was in a long-term relationship at the time of his death. They did not live together and after Adult A moved back into his father's home, it appears that Sean's partner did not visit his home.

In line with Home Office guidance the reviewers wanted to ensure that the review was conducted through the lens of Sean as the victim by reviewing the records and hearing his voice through his family. All members of the family and close acquaintances were contacted by letter, email and telephone and offered advocacy and an opportunity to be part of the review. Reviewers explained to family members the purpose of the review was to ensure the voice of Sean is strong throughout the report, to enable practitioner learning, and to prevent further tragedies.

The family engagement and a meeting with Adult A provided a rounded history of Sean's life and insight into his relationship with his son, Adult A. Their relationship with one another and the

interaction for them both with the wider family evidenced long held pressures between Adult A and his father that were not replicated with Sean and any other family member.

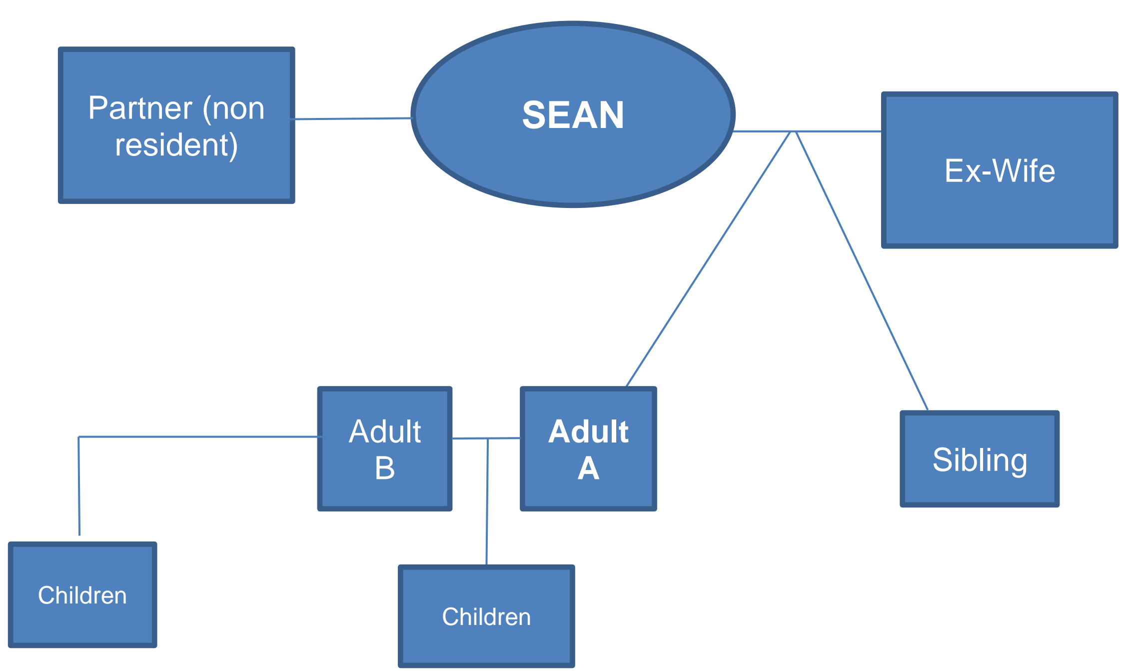
The family have talked of the devastation of losing Sean,

'***He was the beat of a big-hearted family and he has left a hole in our lives that will never be repaired. All our happy memories will be kept forever in our hearts'***

The discussion with family members described Sean as a consistently gentle, warm and generous man, with his family and community both financially and with his time. Adult A's interaction with his immediate family appears to have been a very different picture. Adult A presented one version of himself outside of the home and a very controlling and coercive parent and partner within his home, and this behaviour extended to his father, mother and sibling.

In committing Adult A to a life sentence the Judge referred to how Adult A, subjected his father to a savage attack, showing the elderly man *'not a semblance of mercy'* after he had taken him in.

3. Genogram



4. Sean as described by his family

Sean was born in Ireland and moved to the UK age 10 years old with his family. The family settled in the South Wales area, with Sean successfully completing an apprenticeship with a local firm after finishing school and working for the company for many years. Sean was also a keen football player and had some trials for semi-professional football teams and would speak fondly of his trial for Manchester United with pride. Sean had many interests, he was a skilled craftsman and football was a life-long passion, he enjoyed reading, particularly books on nature, and playing golf and snooker.

Sean had a successful career and was a valued employee and manager within the company. In his personal life, Sean married and had children, his family referred to him as the '*glue*' within his immediate and extended family.

Sean's marriage ended over 25 years ago, but he remained in contact with his ex-wife and would regularly offer practical support and help whenever required. Sean had two children and one has described a very happy life growing up and considered that as children they were *indulged* by their parents. Anything they expressed an interest in was fully explored by Sean and he would encourage them in all hobbies and interests.

Sean is also referred to consistently by all the people we spoke to as a gentle man, happy to help anyone in his local community as well as his extended family. He would regularly assist his older relatives with jobs and errands they needed completing. Sean was a proud Irish man who continued to visit Ireland regularly and kept in touch with his extended family both in Wales, the UK and Ireland. He provided a point of reference for the family for emotional and practical support whenever needed.

The relationship between Sean and his son was considered to be a difficult relationship by all the family. All accepted it was not a close relationship and besides Sean providing for his grandchildren on birthdays and Christian festivals and assisting with household DIY jobs there was little contact with Adult A or his family. Adult A's family were not encouraged to have a relationship with their grandfather, or indeed any of their wider family members outside of the immediate home. All confirmed that Adult A was extremely controlling with who they allowed into their home and who they visited. Adult A did not want to see anyone and he ensured his partner and children did not visit family members on either side of the family.

At times Adult A would allow Sean to visit his home to complete DIY in his home but would always be agitated before he arrived, not welcoming when he was there nor thankful for the jobs he completed for Adult A's family. Adult A would often stay upstairs and not speak to his father while in the house. Sean was welcomed into the home by his grandchildren and Adult A's partner who all considered their granddad to be a lovely, kind and helpful man that they enjoyed spending time with.

The family has shared with the reviewers and panel members many photographs of Sean throughout his life, at home in Ireland and on holiday with his extended family always smiling and happy and in the middle of large family gatherings.

5. Adult A's Background.

Sean had a strong work ethic and arranged for Adult A to complete an apprenticeship and work with the firm he was employed with. Adult A completed his apprenticeship and worked as a skilled worker for 10 years within the same firm as his father. Adult A's relationships with friends growing up were sparse and he was not close to any specific groups. This pattern of behaviour followed on in Adult A's work life and he was always on the periphery of the workforce, even though he was encouraged by Sean and co-workers to join in.

At the time of Sean's death, Adult A had moved back into his father's home after separating from his long-term partner. It appeared to family that Adult A took up his previous position in his father's home that he held prior to moving out and having his own family. Adult A was rigid in his thinking and his behaviour, for example refusing to prepare, eat or share food with his father and not allowing his father into his own kitchen. Adult A's behaviour in controlling the environment while at his home with his family was replicated when he moved back in with his father. Sean started to stay out for longer periods of time. Adult A's family refer to his complete level of control within

the family home as oppressive and accepted by them as the norm. They were not allowed downstairs only to eat in the kitchen at authorised times and then had to retreat to their bedrooms. He would never eat with them as a family and he would never encourage them to have family time together. One of Adult A's children died in adulthood, she was an accomplished writer and wrote publicly about life within the household, how food was used as a form of control and the effect this had on her (attached as Appendix A).

This is the foundation for the first insight into family life with Adult A as a controlling and coercive father and partner within his immediate family. When Adult A started his relationship with Adult B, he ensured all her links with their maternal relatives ceased early on in their relationship.

The family referred to Adult A as appearing to '*rule the roost'* when living with his father as a young man and again on his return to his father's home over twenty years later, This, is how family described the dynamics between Sean and his son, he would not want to upset him and therefore allowed Adult A to use his home the way he wanted to. An example of this is Adult A not allowing his father into the kitchen when he was in there or sharing food with his father. Sean wanted a quiet life and therefore did not challenge his son but accepted the behaviour. Another example provided by the family of how Adult A exhibited control over his father and demonstrated abusive behaviour towards his father when they were in company, Adult A would belittle his father and make him the 'butt' of jokes. Sean appeared to always accept his son's behaviour towards him and the family report that they were embarrassed to witness such events as Adult A physically 'play fighting' with his father. Sean appeared embarrassed and it was viewed as not fair or 'fun' due to the physical difference between them as Adult A was a larger and stronger opponent. This physical behaviour would always be instigated by Adult A and it appeared to the family that again Sean tolerated it. Even though onlookers were at times uncomfortable, no one in the family felt they could challenge Adult A or intervene.

The family spoke of an uncomfortable feeling when Adult A was at home with Sean, and as a result the family would not visit, but Sean would visit everyone's home on his own to keep in touch. The overwhelming feeling within the family was that Sean wanted a quiet life and was possibly scared/intimidated/embarrassed to challenge Adult A and his behaviour towards him.

Adult A had a very strained relationship with his sibling, and they had not spoken for over 20 years. The relationship was described as spiteful from Adult A to his sibling and as a teenager she would choose not to stay in the family home alone with Adult A (then also a teenager), while their parents were at work, due to not feeling safe with him.

When Adult A started a relationship with his partner in 1993, he moved out of his father's home and into his new partner's home with her children within the year of meeting. At this point Adult A was clear he did not want contact with his birth family and would now concentrate on his own family, his partner, stepchildren and the large family they went on to have together.

6. Early signs of controlling and coercive behaviour.

Adult A's behaviour was always controlling as a young adult within his family home and towards his parents and sibling. This level of control and behaviour continued when he started a relationship with his partner and her children. Very early on in their relationship Adult A had convinced his partner that she no longer needed support, friendship or a relationship with her family, and the ties were cut with contacts for her outside the home.

Adult A implied to his partner that she did not need anyone, only him; he would look after her and her children and no one else could be trusted to be there for her. They met on an education course and she was on her final placement when Adult A first self-harmed by stabbing himself

and she states she was forced to terminate her course to look after him. There was no reason for his self-harming behaviour, and he refused to accept any support from health services. However, it was the start of increasing his coercive and controlling behaviour towards his partner. It had the desired effect of her not completing her placement and not taking up a career in the area that she had trained to do.

With hindsight his ex-partner can now recognise the control he used and the extent he went to, to separate her from her family and believe only he would care for her and protect her. At the time of them meeting they were both in education and she never took up the profession as she lost her confidence and started to become very anxious. Physically she refers to becoming vulnerable and unable to emotionally manage without Adult A's support but did not recognise it as controlling behaviour or domestic abuse.

Since separation and cutting ties with Adult A, Adult B is in the middle of successfully completing a professional training course. Within her professional training she has been introduced to the theory of Adverse Childhood Experiences (ACEs) and the Violence against Women Domestic Abuse and Sexual Violence (VAWDASV) Act 2015 Wales, and recognises the coercive control Adult A had over her as domestic abuse. Adult B has started to reflect on the life that the children and family experienced while living with Adult A.

The reality of what her family have lived through and the recognition of how they were all controlled by Adult A is something they are working through as a family. Her understanding of domestic violence only considered physical violence and on two occasions Adult A did physically hurt her, after he consumed large amounts of alcohol. That was clear domestic violence in her mind, and she started to consider what she would/could do and what options of support she had. At that point she felt that refuges were not an option and as she had now cut ties with her family, she felt she had no options but to try and make it work. On reflection she knows that going along with Adult A and his rules and ways of managing the home was abusive towards the children, and herself: through his control of the food they ate, where they went and how they spent most of their young lives in their bedrooms as he would not allow them downstairs.

Adult A appeared to change his behaviour and started to escalate his self-harm by cutting himself if Adult B was not at home or was out for longer than what Adult A considered necessary. Police attended the home on a few occasions whereby Adult A had self-harmed and threatened to kill himself. He always refused further assessment or referral to mental health services and his partner was concerned that if children services were involved the children may have moved out.

Referrals to Mental Health services for Adult A, appear to be a mechanism where he would use the appointments to further his specific needs, such as for evidence for the benefits agency or more specifically to use as a threat over Adult B. In discussion Adult A is clear he contacted mental health services when he wanted to, he did not follow up appointments as he had chosen not to engage with them. In his opinion he did not need them for any specific support or treatment.

Referrals to children's services were seen as 'shameful' by both Adult A and his partner and children's services enquiries always concluded that the children were safe with their mother and it was Adult A's mental health that required attention from his GP and mental health services.

Adult A always used his self-harm to control the environment within the home and he had no intention of accepting assistance from services. He was argumentative towards all services that offered assessment or support with his self-harming (cutting himself and consuming large amounts of alcohol). He refused to ask for assistance and he confirmed that he will continue to refuse all offers of assistance or assessment to try and understand his own behaviour. He accepts that he killed his father and offers no mitigating facts as to why he did this besides his

irritation over the internet access while staying with his father. He recognises that he controlled the environment for his family but again offers no acceptance that this was abusive for his children and partner.

When the schools raised concerns about the stepchildren refusing to return home and wanting to stay with friends due to allegations of physical abuse and emotional abuse by Adult A, they were listened to by children's services and alternative accommodation was sought. Referrals from the school and the Police to children's services were acted upon as single issues with services not enquiring further as to the relationships within the home. We are mindful that this was over 20 years ago and development of communication strategies within policy and processes for lateral checks would now be completed.

The wider impact of Adult A's behaviour on his inherited family, in hindsight, was possibly planned. Removing the stepchildren from the home due to their 'unruly behaviour' may have saved the children from further abuse by him as their stepfather, however accommodation within foster care and residential placements always has a rejection impact for children and the relationship with their mother was severed. An insight into the life of one of Adult A's stepchildren, has been captured and written about. Unfortunately, she has died recently in early adulthood. An example of the coercive control that Adult A as a stepfather is captured in one of her public writings.

'anything that reminded my stepfather of his predecessor tipped him into a rage. It's easy to hide or destroy photographs, but children are harder to discard. Perhaps it was because I looked more like my father than my mother, but I became the target for a lot of this anger, and as such was punished endlessly. But you can become acclimatised to suffering, and eventually even children can become used to physical pain, feeling it less as unendurable beatings and more as a physical form of background music, or a permanent buzzing in your ear. So, the attacks had to alter, take many forms, not just being smacked, but hit with belts, different parts of your body beaten, cold showers for hours, solitary confinement in the dark, and finally, one particular battleground: food.'

The full article is an attached Appendix A.

Adult A had stopped working or attending any education courses and felt entitled to live on state benefits and not to have to provide for his family. This forced the family into a survival mode due to them expanding their family significantly with many children. The size of their family was also a barrier for Adult B when she considered options for leaving Adult A.

When Adult A had his own children, children's services were referred to by the Police when he attempted a significant self-harm episode requiring specialist services to intervene. The children were exposed to traumatic events within the home due to his behaviour. The self-harming behaviour by Adult A proved to be a very powerful weapon within the home to control the situation and the family '*tip toeing'* around him not to upset him or challenge in any way, but to keep the peace. This was a similar pattern for Sean when Adult A returned to live with him. Adult A controlled the home and Sean was almost a guest in his own house, working and living around Adult A. An example of this is the preparation of food and eating together was never an option. Sean was not allowed in his own kitchen only when Adult A was finished and allowed him access. This pattern of behaviour was also reported by Adult A's ex-partner, only Adult A was allowed in the kitchen, the children and Adult B were not allowed into the kitchen if their father was in there preparing meals for them. Adult A chose what everyone would eat and prepare the food with no choice or preference for what the family wanted. Food was used as a punishment with his children and stepchildren and confirmed by his ex-partner, the children would also eat in their

own rooms as Adult A did not want them in the downstairs rooms. Adult B has reported that since Adult A, their father left the family home the children find it hard to sit downstairs or enjoy food without fear. The full article by Adult A's stepdaughter references the impact of food as a punishment and the lifetime effect it.

7. Sibling relationship

The relationship between Adult A and his sibling completely broke down when Adult A started his relationship with Adult B, and he announced to the family that he no longer had a sibling and would be concentrating on his own family. The relationship between the siblings did not improve even when Adult A went on to have his own children. The sibling's children have no relationship with their cousins, and it appears both siblings lived separate lives and had independent relationships with Sean and the rest of the wider family.

8. Functioning family within coercive controls

Sean continued to manage family arrangements for celebrations and funerals accommodating Adult A's wishes, for example different times visiting and attending events such as family funerals, not sitting together with his sibling and keeping a distance from various family members. However, Adult A would manage his anxiety at family functions and in general at community activities that he had to attend. This gave the illusion of a family that functioned and that had no obvious issues of concern.

Adult B related stories of how Adult A would be 'worked up' and very hard to live with prior to any family/community event, but a completely different person at the event. Friendly, chatty and engaging with others. She described him as a Jekyll and Hyde character, he would always keep a very close eye on her and the children and they knew how to behave. Sean was never aware of the extent that Adult A controlled his immediate family. His ex-partner said she hid Adult A's behaviour towards his children from his father as he would have been devastated and would have wanted to sort it out. This would have put the family at further risk and it was easier to try and manage him as they had done.

Adult A was not employed and even though he was a skilled tradesman he rarely left the home. There was an increase in his use of alcohol and a level of high self-neglect with his appearance and personal care, such as sleeping in a chair and not using the toilet, but urinating in the chair and his bed when he used it. A concern for his partner was when he would sit downstairs drinking heavily and the possibility that he would start cutting himself was a constant stress.

9. Father and son early years.

From an early age it has been suggested that Adult A would get his own way as an adolescent with his parents indulging in any activities he had an interest in. Adult A was a conscientious student until the age of 13, where he describes not enjoying the feelings of praise or standing out amongst his peers and he decided to stop trying with his academic studies.

Sean would not challenge Adult A as a child or adult. Rather than challenge, Sean would encourage Adult A with interests and provide the means for Adult A to take up anything he wanted to do to keep him occupied. This pattern continued when Adult A returned to live with Sean over 20 years later. Sean provided the means for hobbies and interests for Adult A. Whether this was to indulge or placate Adult A is not clear.

This pattern of behaviour was referred to prior to Adult A leaving his parent's home, before he started his relationship and also on the return to live with Sean. It had not changed but had become more entrenched and fixed. Adult A did not work outside of the home but refers to being the main homemaker and attending to the family's needs. He refers to being the family cook and he provided meals for all the family daily. He also informed us that he never ate with the family as he was unable to. The kitchen was his domain and the family all accepted that they could not be in the kitchen if Adult A was preparing food. He confirms that was the position also when he returned to live with his father.

10. Significant break in the family/relationship ending

As the children grew up with Adult A, they began to question and challenge their father's behaviour, Adult A started to deteriorate in his self- care and personal hygiene. Adult B had come to the decision that the relationship had to end but had difficulties deciding how to end it. An opportunity arose when Adult A damaged his hand in a self-harming episode and needed to go to the hospital for treatment. Adult B had the locks changed and ensured that Police attended to remove Adult A when he tried to access the home. Adult A initially stayed in his car for a night and Adult B provided him with food and blankets. Even though she recognised the relationship was over she still felt beholden to him to make sure he was comfortable. Adult A moved to a hotel before asking his father to house him. There appears to have been a reluctance from Sean to offer his home immediately to his son, however family have confirmed they believed that Sean offered him a home when he had nowhere else to go. Whether Sean voluntarily offered his home is unclear and all accept that Sean would have been aware that Adult A returning and controlling his home again, would have changed Sean's home environment, as his family and friends would no longer visit. He would still have put the accommodation needs of his son first.

The meeting with Sean's family was some time after his murder and they had reflected on the interactions between father and son and identified an incident that at the time had caused concern but now with a greater understanding of what happened has caused them to question that incident. Sean visited their home, not long before he died. He had walked into a patio door and was falling backwards so they went to hold him and they recall Sean physically flinching as if he was about to be hit. The family commented on it, but Sean was embarrassed, they wonder now if he was enduring physical abuse from Adult A and this is why he started to visit their homes and stay for longer than before Adult A moved in with him. "*It was like he didn't want to be at home".* The panel acknowledge that this is always challenging to consider incidents later with more knowledge and are grateful that the family were able to share their thoughts.

11. Professional records

Practitioner involvement with Sean was only ever through routine health appointments with his GP. Sean was not known to any other community services.

The records available from children services are over 20 years old and after involvement and removal of stepchildren at their request there is little involvement after that. Police referrals to children's services after they attended the house when Adult A had self-harmed were the main referrals. This was viewed as an adult/mental health matter and there appears to be no discussion between adult and children's services areas regarding the impact Adult A's behaviour in the home was potentially having on the children within the home.
Therefore, the family engagement within the review has been key due to the lack of information within professional records and the lack of professional involvement for Sean and Adult A.

12. Protective factors in Sean's life.

Sean had a large extended family that he kept in touch with daily via the telephone and sometimes daily and always weekly visits.

Sean was a skilled and accomplished manager who was well respected within work and had many friends.

Sean was well known and settled in his community, known as a kind and helpful man who would do anything for his neighbours and community. He was known to join in community events and a practical support when needed. He always volunteered and was cheerful and respected by all that met him.

Sean attended his General Practitioner a couple of days before he died and had raised blood pressure.

13. Vulnerabilities for Sean

Sean was a man that wanted no conflict in life, he wanted to be proud of his children and achievements. He would never speak negatively about them, only good.

The relationship Sean had with Adult A as a teenager and young man living together in the family home was strained and compromised co-habitation. Sean would allow Adult A to 'rule the roost', provided Adult A with whatever he expressed an interest in and provided the means for Adult A's alternative diet, as he refused to share any meals with his father, or indeed cook or accept food from his father.

Adult A's behaviour on his return to his father's home appeared to be as entrenched as it was when he was a young adult.

Sean liked to solve problems for his family, at his own expense both emotionally, financially, and physically with Adult A.

14. <u>Themes</u>

As part of a DH-APR, a Learning Event would usually be held to engage with practitioners involved with Sean and Adult A. This was not possible due to the lack of professional involvement for either of them. There were overarching themes identified which have informed the learning points from this review.

The panel considered a full range of possible themes to be considered when addressing the relationship between father and son and any indicators for the family or professionals that could have been identified to prevent this tragedy.

15. Themes in relation to Sean

The only professional that had contact with Sean, was his General Practitioner who has reflected on her interaction with him at that appointment. Sean presented as he always did, dressed very smartly, courteous and no obvious differences in his presentation. His GP was not aware that his son had returned to live with him, and she did not consider the possible wider social and environmental factors that may have been significant with his raised blood pressure. The reflection has enabled the GP to consider not just age as a factor when patients attend with raised blood pressure but consider a wider enquiry as to what else may be happening within their

personal lives. If she had known Sean's son had moved back with his father or enquired about general matters it may have expanded into a discussion regarding stress within the home.

We do not know if Sean would have discussed the situation at home, but this can be considered a missed opportunity.

16. Family's acceptance of Adult A moving back in with Sean.

16.1 The impact that Adult A had on the wider family when he moved back in with his father impacted on them all. Choosing not to visit Sean's home were all symptoms of how they would feel if they visited while Adult A lived there. They chose not to attend his home and accept that Sean would spend extended periods of time with them in their homes and had started to consider what life was like for Sean in his own home.

16.2 The coercive control that Adult A appeared to have over Sean in his own home cannot be underestimated. The change in Sean feeling that he had to leave his home to see people shows a pro-active behaviour by Sean to protect himself and possibly others. Sean's '*flight or fight'* reaction witnessed by his family was evidence that he was becoming hyper-vigilant for his own safety, even when in a safe environment.

17.Themes in relation to Adult A.

All the family accepted that Adult A was different, and from an early age his sibling thought him capable of possibly killing her or their mother, hence them keeping their distance from him and not trying to establish a more meaningful relationship. No one in the family ever considered Sean as at risk from his son.

17.1 Adult A's entrenched non-negotiable and controlling behaviour was established, prior to him meeting his partner and starting his own family. There are suggestions that Adult A had a form of autism but that is still unconfirmed. Adult A did consider that he had autism and had made some attempts to obtain a diagnosis for benefit purposes and to 'appease' his partner. Adult A believes his controlling behaviour is a form of autism as he had researched the behaviours and self- diagnosed himself. He was referred for an assessment by his GP and completed an assessment which was consistent with a diagnosis of Autistic Spectrum Disorder. He declined further appointments and any attempts to engage with mental health services always ended with Adult A not turning up for appointments. The amount of times Adult A self-harmed appears to have been a controlling behaviour to ensure his partner and children did as he instructed. The intensity of his self-harm and self-neglect prior to the relationship ending served to push his partner to end the relationship. This was the opposite of what Adult A had intended to happen. His increase in alcohol and severe self-neglect compounded his partner's and her older children's desire for family life to be different.

17.2 Adult A is clear he did not want help but would play along in order to appease his partner. Attendance at mental health services were only ever piecemeal and he always had a reason as to why he could not engage, for example the room being too big, too small, too crowded or not enough people. He has confirmed he needed a diagnosis for welfare benefit purposes, and he was affronted that he should have to provide any evidence to obtain financial assistance. He refers to attending dog shows with his partner as an '*act of perseverance'*, he never wanted to do it and he accepts that he would be a different person when he had to be outside of the home. He continues today to not engage with support services and states that he is unable to ask for help, because he will refuse to cooperate.

17.3 Adult A continued to try and control his ex- partner after he was arrested. He has been on hunger strikes and continued with his self-harming behaviour informing his ex-partner at each attempt he has made. That has now terminated by her changing her phone number and not opening mail from him.

18. Recognition of Domestic Abuse and specifically Coercion and Control in the relationship between Sean and his Son, Adult A.

The Panel were mindful that coercive control is a significant factor in predicting DHRs and as such wanted to ensure that this was considered and explored in detail.

The recognition of the panel to be open to considering all aspects of Sean's relationship with Adult A enabled a wider consideration of the power and control within the father-son relationship. The panel considered the emotional, controlling and coercive nature of their relationship that appeared to become evident when Adult A was a teenager and continued to escalate when he had his own family and on return to his father's home. He had not changed but became more fixed in his ideas and behaviours to the detriment of those that he lived with.

The Serious Crime Act 2015 created the new offence of controlling and coercive behaviour in intimate or familial relationships and is clearly a form of abuse under the Violence against Women Domestic Abuse and Sexual Violence Act 2015 in Wales (VAWDASV). Due to the nature of this domestic abuse there is a real need for practitioners to identify and ensure that the community in which they work identifies controlling and coercive behaviour as domestic abuse.

It was clear from discussion with the family, Adult A and the available professional records, that the relationship between Sean and Adult A was complex, long standing and not specific to their relationship. Adult A displayed the same behavior when he started to build his own family. He continued to be controlling and abusive to his partner and children throughout their relationship. When he returned to his father's home, he had compounded his controlling behaviors and had very little acceptance of his father, even though he was living in his home.

Sean was clear he felt responsible for Adult A. As a father he felt responsible to assist him when his relationship ended, and he moved back into the family home. Besides Adult A informing us that he asked his father to house him, there is no evidence to support Sean offering him accommodation but rather **not** refusing to house him.

The power of Adult A to return to the family home and to pick up the same controlling and coercive behavior towards his father did have an impact on Sean's physical and mental health. It is well documented that domestic abuse is not recognised within older people and even less recognition with regard to older males. The Hourglass organization report over 37% of domestic abuse is by a son/daughter towards their older parents and 23% toward fathers.

There were no referrals to MARAC or indeed any identification within the family or the very few professionals Sean or Adult A came across that domestic abuse was an issue within his family's home or when he returned to his father's home.

Another aspect and separate element of the Serious Crime Offence is that it must have a 'serious effect' on someone and one way of proving this is that it causes someone to be in fear. On at least one occasion, Sean was seen to physically flinch/cower in a 'fight or flight' response when he was approached from behind by a member of the family after Adult A moved back in with him.

This was a strong response to a non-threatening situation and all the family who were there noted the 'fear' in Sean's response. In order for coercive and controlling behavior to be evidenced,

prosecution need to be able to show that there was intent to control or coerce someone. (https://www.cps.gov.uk/legal-guidance/controlling-or-coercive-behaviour-intimate-or-family-relationship).

Learning Points

Learning point 1– Health Triggers- requiring further investigation

Due to the lack of professional services known to Sean or Adult A, Sean's General Practitioner was the only professional that had seen him before his death. If Sean's rise in blood pressure was a new health issue, or becoming more serious what would the GP have considered as a possible cause? Would the GP discuss his home life or any changes? Would Sean have opened up about the stress he was now living with since Adult A returned to his home? The fact that Sean was staying out of his home for longer periods with his wider family and the impact that may have had on his physical and emotional health may have all played a part in his physical health. Professional curiosity always needs to be at the front of all interactions with each engagement. It may be the only opportunity for someone living within a controlling environment to be able to speak safely.

Learning point 2. – Practitioners' understanding and identification of coercion and control, as domestic abuse within family dynamics, and not just in sexually intimate partnerships.

The family did not talk openly about the relationship between Sean and Adult A as one of domestic abuse but recognised the relationship as complex and not an easy one. The concern that Sean would enable Adult A to dominate him in his own home, so much that they would not raise this with Sean, is possibly a reflection of the concerns they had for themselves with regard to Adult A's behaviour and the possible impact it would have on Sean if they did raise the issues of concern. Previous findings in DH-APRs have focussed on coercive and controlling relationships within families as being considered 'complex' and therefore families are unsure how to address or manage the behaviour and fall into a passive role in order to survive or make the situation less challenging for the victim.

Domestic homicide adult son to father is rare and there are some research findings that give an insight into the characteristics of adult abusers of elderly parents. One of the main characteristics is when an adult child is financially dependent on their parent which occurred with Sean and Adult A. Sean provided housing when Adult A had no other option. He provided food and nourishment and also the week before he was murdered he bought Adult A a car to enable him to be independent. Unemployment rates are higher among abusive adult children, and drug or alcohol problems are common. It is not clear if Adult A's 'autism' impacted on his ability to work, having had a successful early career he was a skilled craftsman, but maybe he chose not to work. In interview, Adult A was clear he could do better than what he was trained to do. By not working outside of the home he was able to have tighter controls over his family and when he returned to his father's home.

Completion of the National Training Framework (NTF) under the Welsh Government VAWDASV Act places a mandatory requirement on all relevant authorities to report annually on the numbers of staff who have completed the Ask and Act training. The levels of the NTF requiring completion is dependent on the role of the professional within an organisation but clearly mandates all levels to complete Group 1(E learning). Further consideration needs to be given to more specific training in regards to coercion and control for practitioners to recognise, enquire and act on when identified.

Learning Point 3 – Coercive control recognised by Practitioners and the Community.

Luke and Ryan Hart refer to their family dynamics as '*the host for their father as a parasite*'. (Remembered forever: mother and sister murdered). They never considered or identified themselves as victims of domestic abuse and did not realise the mortal danger that their family was in. The learning from this review and the tragic death of Sean cannot underestimate the mortal danger that Adult A's ex-partner and her children were living with, and more importantly when the move to separate from Adult A occurred. The identified pathway of eight steps to murder researched and published by Jane Monckton-Smith clearly apply to Adult A's ex-partner and the children. The insight into life with Adult A through his family's perspective and reflections on how they lived and survived with him requires highlighting to improve communication within the community. Coercive control is a more accurate predictor of domestic homicide than is sustained domestic violence, because it reveals the perpetrators belief that they are entitled to control the life of their victim, not simply to hurt them.

Challenges for practitioners when working with families where control is the main driver are difficult to ascertain from the outside. Luke and Ryan Hart refer to the inside versus outside father that had two very different personalities. It therefore makes it so much harder for victims to voice what is going on within the home when the perpetrator shows no evidence of the controlling behaviour or abusive patterns.

Indicators of control and loss of independence needs to be recognised by practitioners as a red flag for possible domestic violence and coercion within families. This was the case with Sean and Adult B and their children. To capture the invisible chains that coercive control has on victims and whole families requires practitioners to look for other signs of abuse and control. It can be viewed as strategic abuse that requires different enquiry by professionals.

Good Practice 1.

Introduction of the IRIS project in some GP practices will enable a raising of domestic abuse awareness in GP practices. The IRIS Programme was developed by the IRISi organisation. The programme is a specialist domestic violence and abuse (DVA) training, support and referral programme for General Practices. The General Practice in this review is now part of this project and has now undertaken the relevant enhanced training.

Good Practice 2.

Mandatory VAWDASV training for all relevant authorities will increase awareness and knowledge across practitioners. The formal reporting to Welsh Government required by each agency ensures completion.
In November 2017 the Welsh Government outlined a national approach for medical professionals to use to identify if domestic abuse was a factor for patients seeking medical assistance; this was referred to as 'Ask and Act'. It has been introduced as legislation in Wales. The elements of this guidance that are most relevant in this case are those that consider the threshold point at which practitioners assess whether to ask patients specifically if they are suffering from domestic abuse. The approach is not to ask every patient that is seen by a health professional if they are a victim of such abuse (such an approach would be a 'Routine Enquiry'). Rather, practitioners are trained to look for 'cues' and 'signs' that a person may be the victim of domestic abuse. If the health professional develops the view that a person may be experiencing such abuse, they will consider if they should carry out a 'Targeted Enquiry' and ask that person directly. Ask and Act training was provided through the VAWDASV Board and available to GPs to access.

Good Practice 3

The regional safeguarding Board have developed bespoke training for multi-agency professionals who work with older people. The purpose of the course is to increase awareness and knowledge amongst a range of practitioners, of forms of intra-familial abuse and 'harm' experienced by older people, including the recognition of domestic abuse. To develop a greater understanding of complex family and family carer dynamics, as well as other issues (barriers, discrimination etc.) faced by older people, who may/may not have complex physical health needs, disabilities, cognitive impairment and/ or psychological needs.

Good Practice 4

Dewis choice book in Wales

The Centre for Age, Gender and Social Justice has developed free training and guidance for practitioners who work with older people experiencing domestic abuse or care-giver stress. The training and guidance are informed by research conducted at the Centre, including the first longitudinal study to draw directly on older people's lived experiences of help-seeking. Free online training courses at the Centre come in bite-sized formats and are easily accessible to a wide range of practitioners.

If you are a practitioner looking for advice or support in a specific area relating to older people, domestic abuse and care-giver stress, contact for confidential advice is available at hello@dewiscHoice.org.uk

Resources - Centre For Age Gender and Social Justice (dewischoice.org.uk).

Improving Systems and Practice

In order to promote the learning from this case the review identified the following actions for the SCB and its member agencies and anticipated improvement outcomes:-

Learning Point 1

Health Triggers- requiring further investigation

Learning Point 2

Practitioners understanding and identification of coercion and control, as domestic abuse within family dynamics, and not just in sexually intimate partnerships.

Learning Point 3

Coercive control recognised by Practitioners and the Community.

In Summary

To capture the invisible chains that coercive control has on victims and whole families requires practitioners to look for other signs of abuse and control rather than rely on traditional indicators of physical abuse. Coercive control can be viewed as a form of strategic domestic abuse that requires a different set of enquiries by practitioners. The interaction of victims with professional services will be controlled by their perpetrator even if they are not in attendance. It is therefore important for all professional interactions to be open to the possibility of coercive control within their relationships.

Adult abuse against parents

Research in regard to child/adult abuse on their parents refers to three categories that also need to be considered, 1, ***hostile children***: *2,* ***authoritarian caregivers***: *3* ***dependents***. Even though we have established that Adult A was not a caregiver to Sean, he was an *authoritarian care giver* to his children and then became an authoritarian figure within Sean's home. Authoritarian adult/children can have a domineering, rigid, punitive personality. Research describes them as critical, impatient, and blunt. Adult A evidenced all of these behaviors from an early age. They became compounded and entrenched with his own parenting towards his children and his behavior towards his partner. All of these behaviors were evident with Adult A for the majority of his life.

Older people will soon be the largest segment of society. Research indicates that elder abuse will increase. Since families still provide a majority of care for aged loved ones, analysts believe that adult children will continue to abuse. Research allows for the profiling of adult children who abuse elderly parents. It also offers a typology for understanding their actions. Moreover, traditional theories provide a general understanding of this type of abuse, while new, integrated theories focusing on internal and external factors provide complex models for study. Applying these theories to abuse-reduction strategies offers a great deal of promise for alleviating the problem of elder abuse perpetrated by adult children. The inclusion of domestic abuse research and theories need to be intertwined within all abuse against older people, so we do not lose coercive control as a lens to view abuse.

The final words are from Sean's family and their inclusion in the review enabled insights into the family dynamics that we were unable to get from any professional records, due to Sean and Adult A not being known to public services or specialist services in the community.

"Although the report had many details we did not know about, we felt that your insight and advice gave us greater clarity on subjects alien to us.

We came away from the meetings, although extremely emotional, you both have equipped and helped us to start to grieve Dad and finally have closure to the unspoken details of domestic homicide murder.

We once again are so grateful for your kindness and support throughout this process".

Bibliography:

1. Brandl, Bonnie, and Loree Cook-Daniels. Domestic Abuse in Later Life: Who Are the Abusers? Washington DC: National Center on Elder Abuse, 2003.
2. Hart, Luke and Ryan, Remembered Forever. Seven Dials 2019
3. Hart, Luke and Ryan, Operation Lighthouse. CoCo awareness 2018
4. Monckton-Smith Jane, In Control: Dangerous relationships and how they end in murder.2021

Appendices

A. Family reflection on growing up with perpetrator.
B. Draft action plan.

<table>
<tr><th colspan="4">Statement by Reviewer(s)</th></tr>
<tr><td>REVIEWER 1</td><td>Mary Ryan
Head of Corporate Safeguarding Newport City Council.</td><td>REVIEWER 2</td><td>Ann Hamlet
Head of Safeguarding Aneurin Bevan University Health Board</td></tr>
<tr><td colspan="2">Statement of independence from the case
Quality Assurance statement of qualification</td><td colspan="2">Statement of independence from the case
Quality Assurance statement of qualification</td></tr>
<tr><td colspan="2">I make the following statement that prior to my involvement with this learning review:-

• I have not been directly concerned with Sean, Adult A or the wider family, or have given professional advice on the case.

• I have had no line management of the practitioner(s) involved.

• I have the appropriate recognised qualifications, knowledge and experience and training to undertake the review.

• The review was conducted appropriately and was rigorous in its analysis and evaluation of the issues as set out in the Terms of Reference</td><td colspan="2">I make the following statement that prior to my involvement with this learning review:-

• I have not been directly concerned with Sean, Adult A or the wider family, or have given professional advice on the case

• I have had no immediate line management of the practitioner(s) involved.

• I have the appropriate recognised qualifications, knowledge and experience and training to undertake the review.

• The review was conducted appropriately and was rigorous in its analysis and evaluation of the issues as set out in the Terms of Reference</td></tr>
<tr><td colspan="2">Reviewer 1
(Signature) Mary Ryan

Name: Mary Ryan

Date 25/09/2021</td><td colspan="2">Reviewer 2
(Signature) Ann Hamlet

Name: Ann Hamlet

Date 25/09/2021</td></tr>
</table>

Chair of Review Panel

Name: DCI Martin Price Gwent Police, promoted to Superintendent in Public Protection during the review period.

Mr Price had no connection with the family prior to the murder and had no connection with the criminal investigation and court process.

Date 25/09/2021

DH-APR process

To include here in brief:

- *The process followed by the SCB and the services represented on the Review Panel*
- *A learning event was held and the services that attended*
- *Family members had been informed, their views sought and represented throughout the learning event and feedback had been provided to them.*

Reviewer: Ann Hamlet, Head of Safeguarding, Aneurin Bevan University Health Board

Reviewer: Mary Ryan, Head of Corporate Safeguarding, Newport City Council

Chair of Panel: Martin Price

The services represented on the panel consisted of:

- Torfaen county council
- ABUHB
- Gwent Police
- Public Protection and Community Services
- VAWDASV lead for Gwent region (Violence Against Women Domestic Violence and Sexual Violence) who liaise and represent 3rd sector/voluntary involvement in the panel.
- Welsh Ambulance Service Trust

The Panel met regularly from the initial Case Review Safeguarding group on 11.02.2020, to determine the panel and appoint the reviewers to the panel meetings.

The Panel meetings
01.06.2020
01.07.2020
06.08.2020
07.09.2020
12.10.2020
17.12.2020
02.02.2021
22.03.2021

Final meeting on 07.09.2021 in order to review the multi-agency information and provide analysis to support the development of the report. The Coronavirus pandemic extended the review period due to a delay in meeting with the family, wider members and meeting with Adult A.

Terms of Reference
Concise Domestic - Adult Practice Review (DH-APR)

These Terms of Reference set out the scope of this pilot which intends to carry out a Domestic Homicide Review (DHR) using the Adult Practice Review (APR) process. Therefore, these Terms of Reference represent a hybrid of DHR and APR methodologies which will guide the pilot process and will be used to inform the development of future review procedures.

"Domestic Homicide Review" means a review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by:

(a) a person to whom he was related or with whom he was or had been in an intimate personal relationship, or

(b) a member of the same household as himself,

Held with a view to identifying the lessons to be learnt from the death. (Home Office, Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews, December 2016)

The above criterion for a Domestic Homicide Review needs to be satisfied in order for a case to qualify to be reviewed using the Adult Practice Review process.

Determine whether decisions and actions in the case comply with the policy and

- Procedures of named services and Board.
- Examine inter-agency working and service provision for the individual and family.
- Determine the extent to which decisions and actions were individual focused.
- Consider whether family and friends are prepared to participate in the review.
- Seek contributions to the review from appropriate family members and keep them informed of key aspects of progress.
- Assess the extent to which family and friends were aware of abusive or coercive/controlling behaviour from Adult A to Sean.
- Review any barriers experienced by the family in reporting abuse or concerns, including whether they (or Sean) knew how to report or recognise familial domestic abuse had they wished to.
- Review any previous concerning conduct or a history of abusive or coercive/controlling behaviour from Adult A and whether this was known or acknowledged by agencies.
- Assess whether it would have been possible to conduct a Multi-Agency Risk Assessment Conference.
- Assess whether Adult A had any previous history of abusive behaviour or coercive/controlling towards previous partner.
- Review communication to the public and non-specialist services about available specialist services related to domestic abuse or violence.

- ***Head of Safeguarding***
- ***Llanfrechfa Grange Hospital***

- Take account of any parallel investigations or proceedings related to the case.
  Hold a learning event for practitioners and identify required resources if appropriate.

In addition to the review process, to have particular regard to the following:

- Whether previous relevant information or history about Adult A and/or family members was known and taken into account in professionals' assessment, planning and decision-making in respect of Adult A, the family and their circumstances. How that knowledge contributed to the outcome for Sean.

- Whether the actions were implemented effectively, monitored and reviewed and whether all agencies contributed appropriately to the development and delivery of the multi-agency actions.

- The aspects of the actions that worked well and those that did not work well and why. The degree to which agencies challenged each other regarding the effectiveness of the actions, including progress against agreed outcomes for Sean and Adult A. Whether the protocol for professional disagreement was required or invoked.

- Whether the respective statutory duties of agencies working with Sean and Adult A were fulfilled.

- Whether there were obstacles or difficulties in this case that prevented agencies from fulfilling their duties (this should include consideration of both organisational issues and other contextual issues).

Specific tasks of the Review Panel

- Identify and commission a reviewer/s to work with the *Review Panel* in accordance with guidance for concise and extended reviews.

- Agree the time frame.

- Identify agencies, relevant services and professionals to contribute to the review, produce a timeline and an initial case summary and identify any immediate action already taken.

  Relevant panel member agencies and contributors to the Review are:

  - Torfaen County Borough Council – Kate Williams: Group Manager, Torfaen County Borough Council, Gill Pratlett, Head of Adult Social Care
  - ABUHB – Ann Hamlet, Head of Safeguarding Aneurin Bevan University Health Board (Report Reviewer)
  - Gwent Police – Alun Davies, Detective Superintendent. DCI Martin Price Gwent Police, promoted to Superintendent in Public Protection during the review period – D-APR Chair
  - Public Protection and Community Services – Andrew Tuck, Public Protection Lead, Gwent Police
  - VAWDASV (Violence Against Women, Domestic Abuse and Sexual Violence) – Janice Dent, Regional Partnership Services Coordinator.
  - Welsh Ambulance Service Trust – Head of Safeguarding.
  - Report Reviewer – Mary Ryan, Head of Corporate Safeguarding Newport City Council.

  Governance

  - Home Office
  - Public Service Board (Torfaen County Council) – as a governing body. Pilot progress will be reported to CSPs by CSP Coordinator who is a panel member.

- Produce a merged timeline, for initial analysis and hypotheses.

- Plan with the reviewer/s contact arrangements with family members prior to the event.

- Ensure that advocacy options are offered to family members, including a ‘consent to share’ option. Even if not accepted, this will attempt to ensure that family members are fully aware of what is available to them at every stage of the review process. To review the offer of these advocacy options regularly throughout the review process. To ensure that when making family members aware of their advocacy options that this is done in a way that is respectful of the family’s choice.

- Receive and consider the draft adult practice review report to ensure that the terms of reference have been met, the initial hypotheses addressed and any additional learning is identified and included in the final report.

- Review best practice in respect of protecting adults from domestic abuse.

- Draw out conclusions about how organisations and partnerships can improve their working in the future to support victims of domestic abuse at local, regional and national levels.

- Agree conclusions from the review and an outline action plan, and make arrangements for presentation to the Home Office QA Group, the Public Service Board, the Case Review Group Gwent safeguarding board for consideration and agreement.

- Plan arrangements to give feedback to family members and share the contents of the report following the conclusion of the review and before publication.

Tasks of the Safeguarding Board

- Consider and agree any Board learning points to be incorporated into the final report or the action plan.

- Review Panel completes the report and action plan.

- Board sends to relevant agencies for final comment before sign-off and submission to Welsh Government.

- Confirm arrangements for the management of the multi-agency action plan by the Review Sub-Group, including how anticipated service improvements will be identified, monitored and reviewed.

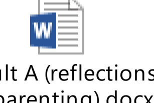
- Plan publication on Board website.

- Agree dissemination to agencies, relevant services and professionals.

- The Chair of the Board will be responsible for making all public comment and responses to media interest concerning the review until the process is completed.

END

A. Reflections of family member growing up with Adult A.



B. Action Plan

Held by local authority

Equality and Diversity

The Equality Act of 2010 enshrined nine ‘protected characteristics’ in order to ensure people are legally protected from discrimination[1]. This legislation applies to many areas of a person’s life; in the context of this review, the way in which the victim and perpetrator used and received public services, specifically local health services, will be considered in detail.

[1] https://www.gov.uk/discrimination-your-rights