Safeguarding Partnership Board

DOMESTIC HOMICIDE REVIEW

In respect of the death of Pamela, August 2019

LEARNING SUMMARY

Professor Jane Monckton Smith, Independent Author

August 2021

Pamela

Pamela was a wonderful wife, mother, grandmother and friend and she is sorely missed; she was devoted to her husband and she adored her sons and her grandchildren. She was a huge part of so many people's lives who will mourn her loss forever, in many ways their lives will never be the same again, but memories of Pamela will stay with them. She was a lovely lady who worked hard for her family and friends as well as those less fortunate than herself.

Pamela went to Cambridge University and gained a B.Ed. before spending many years teaching History in a large South London comprehensive school for girls. Following this she became an instructor at a Special Education Unit for school excluded pupils in Lambeth as well as becoming a freelance editor of history textbooks for a publishing company. In addition to her paid employment Pamela used her knowledge and expertise in a voluntary capacity and became a member of the Board of Governors of 2 London schools before moving to Jersey in 1987 with her husband and young family.

In Jersey Pamela became a Constable's Officer in St Peter's Honorary Police from 1989 to 1995, she was a member of the Youth Court Panel of the Magistrate's Court from 1996 to 2005 and she also worked for the Jersey law Society from 2007 to 2013. Pamela was a Rate Assessor for local parishes and volunteered with many charities, such as Riding for the Disabled, RSPB, Age Concern and Jersey Cheshire Homes.

Pamela always did as much as she could to help those less fortunate than herself, not only by working but by volunteering and giving her time to many charities. People enjoyed her company because she had a warm welcoming personality and a good sense of humour. She was very knowledgeable and understood how some people struggle with life and did her upmost to help them. She had a great sense of community and a commitment to giving to those less fortunate than herself.

Losing Pamela has left a huge void in many people's lives and the pain of losing her will never fade. It will never go away and she will always be loved and remembered with fondness.

Contributed by Pamela's family

1.0 List of Contents

2.0 Glossary

ASD - Autism Spectrum Disorder

DHR - Domestic Homicide Review

IDVA - Independent Domestic Violence Adviser

IRIS – Identification and Referral to Improve Safety

IMR - Individual Management Reviews

JAMHS – Jersey Adult Mental Health Service

JDOC – Jersey Doctor on Call

MARAC - Multi-Agency Risk Assessment Conference

RIC – Risk Identification Checklist

SoJP – States of Jersey Police

3.0 Preface

I would like to begin this Learning Summary by expressing my sincere sympathies and that of the Panel, with the family and friends of Pamela who is remembered universally as a kind and energetic person who is keenly missed. Throughout the report the pseudonym of Steven shall be used.

The DHR was a difficult review to write and for many it was difficult to read. This Learning Summary may also be difficult to read although some of the detail pertaining to Pamela's death has not been included in this report out of deference to her husband, her younger son, and his family. The DHR was complex in part because there are multiple lenses through which the antecedents can be assessed. The UK Home Office guidance for conduct of a Domestic Homicide Review was followed and therefore, the antecedents were assessed through the lens of domestic abuse and coercive control and as far as possible, centred the perspective on the victim of the homicide, Pamela. Coercive control, domestic abuse and domestic violence are not clinical conditions, but patterns of behaviour that are described by Stark (2009) [1]as creating an interpersonal predicament that contains predictable elements, follows typical patterns, has typical consequences and predictable outcomes.

There is little doubt from the legal proceedings and the medical expert opinion, that mental illness was a factor in this case, and this influenced the acceptance of the plea of guilty to manslaughter on the grounds of diminished responsibility from Pamela's son. This resulted in an indefinite hospital order rather than a prison sentence. The DHR did not attempt to assess Steven's mental health, that had been done; the DHR considered the domestic relationships and any escalating risk of harm to Pamela that may have been identified by professionals. It became very clear, after gathering information, that Pamela was subjected to patterns of behaviour from Steven that fit the criteria for domestic violence and coercive control and this abuse was focused particularly on her. However, other family members were also subjected to coercive control of a serious and intense nature.

The DHR was conducted in line with the Jersey Safeguarding Partnership Board Information Sharing Protocol. The DHR also followed the UK Home Office Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews (2016) with the purpose of identifying improvements which could be made to community and organisational responses to victims of domestic abuse, with the objective of preventing tragedies such as this from happening again.

Jane Monckton Smith

Independent Author

[1] Stark,E. (2009), *Coercive Control: The Entrapment of Women in Personal Life,* Oxford University Press.

4.0 Review Process

4.1 This document is a learning summary of the Domestic Homicide Review (DHR) that was held to examine agency responses and support given to Pamela**,** prior to the point of her death in August 2019.

4.2 Pamela was killed by her eldest son by a single stab wound to the neck, in August 2019.

4.3 There had been a history of concerning and dangerous behaviours from Steven at Pamela's home and the police and other agencies were called for assistance on more than one occasion.

4.4 The decision to hold a Domestic Homicide Review (DHR) was taken by the Jersey Safeguarding Partnership Board in July 2020.

4.5 The UK Home Office Multi-Agency Statutory Guidance for the Conduct of DHRs was followed together with the Jersey Safeguarding Partnership Board Information Sharing Protocol.

4.6 Professor Jane Monckton Smith was appointed as the Independent Author of the Domestic Homicide Review Report in August 2020.

4.7 All agencies were asked to search their records for any contact with Pamela and her eldest son and those who were identified as having significant contact were asked to provide an IMR detailing the contact and analysing the way the contact was handled.

4.8 Agencies who provided IMRs were Primary Care, Family Nursing and Home Care, Children's Social Care, Health and Community Services, Adult Mental Health, States of Jersey Police, Jersey IDVA Service.

4.9 In addition to agency involvement the DHR examined the past to identify any relevant background or trail of abuse before Pamela's death, whether support was accessed within the community and whether there were any barriers to accessing support.

4.10 By taking a holistic approach the review sought to identify appropriate solutions to make the future safer. This learning summary report summarizes the circumstances that led to a DHR being undertaken in this case.

4.11 This learning summary details the lessons to be learned from Pamela's death particularly as domestic abuse was a relevant factor.

4.12 For these lessons to be learned as widely and thoroughly as possible, professionals need to be able to understand fully what happened and most importantly, what needs to change in order to reduce the risk of such tragedies happening in the future.

5.0 Contributors to the Review

- States of Jersey Police
- Health & Community Services
- Mental Health Service
- Family Nursing & Home Care
- Children's Services
- Jersey Domestic Abuse Support
- Women's Refuge
- Ambulance Service
- GP
- Pamela's Family

6.0 The Review Panel Members

Group Director - Chair	Customer &Local Services Chair
Executive Assistant	Safeguarding Partnership Board
Superintendent	States of Jersey Police
Associate Medical Director	Adult Mental Health Services and Social Care
Associate Service Director	Adult Social Care & Mental Health
Safeguarding Lead for Adults and Children	Family Nursing and Home Care
Director of Safeguarding	Children, Young People, Education & Skills
Associate Medical Director	Primary Care
Service Manager	Jersey Domestic Abuse Support (IDVA)
Manager	Jersey Women's Refuge
Independent Author	

7.0 Author of the Overview Report

Professor Jane Monckton-Smith was appointed by Jersey Safeguarding Partnership Board as Independent Author of the Overview Report in November 2020. She is a Professor of Public Protection at the University of Gloucestershire with a specialism in homicide. She lectures in criminology and criminal investigation and is an active researcher published in the area of domestic homicide and forensic investigation. Professor Monckton Smith trains police and other professionals in advanced risk and threat assessment in the area of coercive control, stalking and domestic abuse and works with a number of homicide and stalking charities helping victims and professionals understand domestic homicide and domestic abuse and stalking.

Professor Monckton Smith has no involvement with any of the agencies involved in the DHR into the death of Pamela.

8.0 Terms of Reference for the DHR

1. To review the involvement of each individual agency with Pamela and Steven and immediate family during the relevant time period from January 2017 to August 2019.
2. To review current roles, responsibilities, policies, practice and law in Jersey to provide a picture of the protection and safeguards that are in place for potential victims of domestic abuse.
3. To review the above against what happened, to draw out strengths and weaknesses of current arrangements.
4. To establish whether there are lessons to be learned from the case about the way in which local professionals and agencies work together to identify and respond to, disclosures of domestic abuse.
5. To identify clearly what those lessons are, how they will be acted upon and what is expected to change as a result.
6. To prepare a report in a form that can be published.
7. To prepare learning materials for dissemination of learning.

The Overview Author will seek to engage with the family and listen to their experience leading up to the death of their family member.

Domestic Homicide Panel

A Domestic Homicide Panel will be made up of senior representatives from the Safeguarding Partnership Board with a relevant area of focus for the review to include:

- Adult Mental Health Services
- Adult Social Care
- Police
- Children's Services
- Family Nursing and Care
- Primary Care

The Domestic Homicide Panel will be chaired by an individual whose organisation has not had any involvement in the case.

The purpose of the panel is to:

- Approve the DHR methodology and provide advice and support to the DHR author in establishing their review framework.
- Act as a co ordinating point for collating key documents and reports for the DHR including individual management reports.
- Facilitate any events such as practitioner learning events relating to the DHR.
- Act as a conduit for communication with the family of Pamela
- Ensure the agreed timetable for the DHR is maintained, review and authorise any extensions to this.
- Receive drafts of the DHR report and quality assure these ahead of finalisation of the report.

This Domestic Homicide Review (DHR) is conducted in line with the Jersey Safeguarding Partnership Board Information Sharing Protocol. Information shared for the purpose of the DHR will remain confidential to the Panel until the Panel agree what information should be shared in the final report, when published. The DHR also follows the UK Home Office Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews (2016).

9.0 Summary

9.1 Pamela was a retired teacher who became a magistrate and honorary police officer.

9.2 Her eldest son, her killer, qualified as a medical doctor in 2003 and was diagnosed with Autism Spectrum Disorder (ASD) in 2004.

9.3 He met his partner in 2012 and they moved to Country A in 2014.

9.4 They returned to Jersey unexpectedly a few days before Christmas in 2016 but Pamela and her husband did not want them to stay longer than a few days, so they returned to their home in the UK.

9.5 In November 2017 they returned to Jersey and Pamela and her husband allowed them to stay in the one-bedroom annex of their home on a temporary basis.

9.6 Steven wanted to develop the annex accommodation for himself and his family on a permanent basis, but Pamela and her husband thought the annex unsuitable and refused to agree. They provided alternative accommodation for Steven and his family, but he was fixated on his plans to renovate the annex and stayed in the annex refusing to move out and started to apply significant pressure on his parents to allow him to have control of their property.

9.7 When his demands were not met Steven made two suicide attempts but later admitted that they were not serious attempts but were used as a method to control those around him and apply pressure to his parents. He then routinely threatened to kill himself if they did not comply with his demands.

9.8 As a result of the second suicide attempt Steven broke both his ankles and spent some time in hospital in casts before returning to live at his parents' home where he was looked after by his father and Pamela.

9.9 Following this suicide attempt in January 2018, his first encounter with mental health services took place in the hospital and he is reported as saying that he blamed Pamela, his mother, for his actions.

9.10 Steven was very antagonistic towards Pamela as he perceived that she was the barrier to him achieving his demands, although Pamela was helping his partner and baby.

9.11 Steven's motivation was to get his parents to change their minds and allow him to develop the annex and at some point, this changed into a demand to have legal ownership of his parents' home.

9.12 In March 2018, it was considered by all that Steven could be discharged from mental health services support. Not long after this decision Pamela rang the GP concerned about Steven's mental health – his threats to self-harm, depression and agitation. The GP made a home visit noted the continuing issues that Steven had about developing the annex.

9.13 The Community Mental Health Nurse offered Steven an assessment with a consultant psychiatrist, in June 2018, but this was refused. Pamela phoned the out of hours GP Service, JDOC, as she was concerned - Steven had become increasingly agitated, threatening self-harm, arguing with his brother, stopped taking his prescribed antidepressants and was no longer being seen by the mental health service.

9.14 The GP made a visit and GP contact was maintained as concerns continued.

9.15 In March 2019, the GP contacted the Community Mental Health Nurse for support with the domestic situation and in April contacted JAMHS about the risk of self-harm that Steven was threatening.

9.16 States of Jersey Police (SoJP) had been in contact with the family since April 2019. The address was flagged with '*treat calls as urgent'*. There were no arrests, as Pamela and her husband were reluctant to criminalise Steven's behaviours.

9.17 The situation with Steven and his parents deteriorated due to his insistence that he be allowed to have legal ownership of their property. He often shouted at his parents and would constantly harangue them to get them to change their minds, for hours at a time. He was violent and abusive towards Pamela and persistent, intense and rigid in his demands and thinking.

9.18 It became so difficult that Pamela and her husband had no alternative other than to try to formally evict their son from their property. The eviction notice was served on him in July 2019 with the end of the month as the date by which he and his family would be expected to vacate the property.

9.19 Once the notice was served Steven's harassment and abuse of his parents escalated as he made continuous attempts to force them to change their minds about allowing him to take legal control of the property. Police had to be called on several occasions to remove him from his parents' home when he refused to leave.

9.20 Steven claimed that he was being made homeless (this was not true); he claimed discrimination from Pamela (no evidence supports this claim).

9.21 Steven's behaviour did not improve, and Pamela and her husband found the situation intolerable and upsetting, they described Steven as confrontational and manipulative.

9.22 As the eviction drew nearer and Steven's high-risk behaviours grew, the GP and the consultant psychiatrist attempted to detain Steven using Mental Health law. This was attempted on three occasions in fairly short amount of time. The first two attempts were postponed due to barriers created by Steven. At the third and final attempt, the authorised officer refused to allow the detention of Steven under mental health law, believing that the situation could be managed without detaining Steven.

9.23 On a Tuesday in early August 2019, States of Jersey Ambulance Service received an emergency call from Pamela's husband requesting immediate assistance to his home address where Pamela had been stabbed in the neck and was bleeding badly. Steven was named by his father as being responsible for stabbing his mother with a knife. Steven had taken a knife to the scene and had physically prevented his father administering emergency aid to Pamela. Pamela was pronounced dead at the hospital later that evening.

9.24 Steven was arrested and charged with murder but later pleaded guilty to manslaughter due to diminished responsibility. He was sentenced to an indefinite hospital order and had an indefinite restraining order placed on him precluding him from contacting his father or wider family.

9.25 The key purpose for undertaking the DHR was to enable lessons to be learned from Pamela's death particularly as domestic abuse was a relevant factor in her death.

9.26 For these lessons to be learned as widely and thoroughly as possible, professionals need to understand fully what happened and most importantly what needs to change in order to reduce the risk of such tragedies happening in the future.

10.0 Key Issues Arising from the Review

10.1 The DHR was a complex review, largely because of the multiple issues occurring simultaneously, only some of which were fully identified. There was a definite focus on Steven, his mental health, his distress, his self-harm and his wishes and demands. This focus created a smokescreen around the other issues occurring as a result of Steven's behaviours. Most notably, the domestic abuse and control suffered by Pamela, Steven's father and brother and the impact on the physical and mental health of Steven's child and the impact on his partner.

10.2 The DHR focused on the impact on Pamela, who lost her life at the hands of Steven. It is accepted that Steven was diagnosed with ASD and could also have various traits consistent with certain personality disorders. It must also be accepted that he was abusive, manipulative, controlling and threatening. This analysis must focus on these behaviours, they are important irrespective of what was driving them. The risk posed to Pamela was not fully recognised because of the focus on Steven and his potential risk to himself. There has been a mental health case note review by Jersey Health and Community Services.

10.3 The DHR also considered any barriers to reporting that impacted on Pamela and her family. In this case and many others where domestic abuse and coercive control are relevant, victims of it can feel divided in their loyalties. Pamela loved her son and was conflicted about how the escalating risks should be managed. She did not want to criminalise her son's behaviours; she wanted his mental health addressed and the situation dealt with through that lens. She told police this and was resistant to them prosecuting or arresting Steven. This is probably one of the more consistent barriers to criminal justice intervention where there is a family dynamic.

10.4 Coercive control can and does exist independent of any diagnosed mental health disorder as a recognised pattern. The pattern itself presents risks to its victims and proceeds in a predictable way with predictable outcomes. The DHR did not ignore Steven's mental health; but focused instead on the patterns of coercive control that were operating irrespective of any underlying cause or issue that may have created them. The coercively controlling patterns are the focus for this analysis.

10.5 Coercive Control: The offence of 'coercive control' is now defined in law in many countries (and currently under consideration for introduction in Jersey as part of a draft Domestic Abuse Law) however, the patterns and behaviours exist independent of their legal definition and as noted, are considered the best model for understanding domestic abuse, escalating risk and its impact on the victim.

10.6 Risk assessment: Risk is a dynamic concept and risk assessment is not a precise science. However, recognising controlling patterns and cycles can help a professional recognise when risk is elevated or elevating. In this case there is clear evidence of controlling patterns and high-risk characteristics. The following are some of the known and recognised high risk markers in cases of domestic abuse and coercive control that often appear on RICs:

10.7 Controlling patterns: Steven was trying to manipulate the situation and the people within it, with a specific end in mind. His behaviours were designed to get people to comply with his demands. The patterns of control were operating in parallel with, and may be because of, Steven's diagnosis of ASD and other issues. In this case the controlling patterns dominated the situation and were creating a recognisable pattern to recognise the escalation in risk.

10.8 Violence: Steven used violence when people around him did not comply with his demands. Pamela was personally subjected to his violence; he would also throw furniture around and used violence against himself.

10.9 Threats of suicide: Steven regularly threatened suicide to try and get compliance from others. There were two quite dramatic events where Steven harmed himself deliberately, but to achieve compliance, not as an attempt to kill himself.

10.10 Gaslighting and persuasion of others: So-called gaslighting is a tactic that has the aim of making a victim of it question their own judgement, or make others believe the victim is an unreliable witness. In this case, Steven made clear attempts to manipulate others into believing he was rejected and discriminated against.

10.11 Fear in victims: Victims of coercive control often know the extent of the threat posed to them. If they are afraid, research has shown this is one of the clearest indications of risk. Stark (2009) states that the controlling person 'sets in the mind of his victim the price of their resistance'. Pamela was frightened of Steven's behaviour she had said so, she increased her personal security, she called police and others for help and support. Steven repeatedly said there would be consequences for non-compliance and this threat was often that he would kill himself.

10.12 Isolation: Controlling people will attempt to isolate their victim from the support, help or influence of others. Steven consistently tried to make Pamela look like he was a victim of her. He told professionals of her control, her rejection of him, her discriminatory views, her narcissism and his entitlement to her property by describing it as the 'family home'. None of these things were true, but the focus on Steven's mental health, started to present Pamela as the problem for some, notably his partner and at least one professional who is not part of this panel.

10.13 Tracking and Monitoring: Steven was tracking his conversations with Pamela and was recording them, then listening to them repeatedly.

10.14 Control of others: Steven was not only exerting control over Pamela, there was control over other members of family and attempts to control professionals. Steven's father was harangued over hours as he followed him around the property demanding it be signed over to him. His father had to watch the abuse of Pamela. His life became dominated by Steven and his demands. Steven had also attempted to control his brother and family. It seems that everyone in Steven's family – his partner, his parents, his brother – were all complying with unreasonable and increasingly dangerous demands to try and pacify Steven.

10.15 Minimising abuse: There is little doubt that initially the abuse and control suffered by Steven's family was not fully disclosed to professionals before Pamela's death and maybe is not fully disclosed now. It is a known and acknowledged response to domestic abuse and coercive control that victims of it will minimize their experiences and this can be for many reasons.

10.16 These are just some of the more obvious high-risk markers, there are some still hidden. However, the DHR looked at events and responses to events, through the lens of domestic abuse and coercive control – always accepting the mental health diagnoses.

History and context of Steven's demands

10.17 Steven was fixated on the idea that he should have control of his parent's home. He wanted a controlling ownership. Although it is uncomfortable to consider, the root of this aspiration may help to structure what appears to be a chaotic and delusional demand. Steven is not the owner of his parent's property and has no legal lien.

10.18 Steven had been living in Country A with his partner.

10.19 Pamela lived in Jersey in a comfortable home that she owned with her husband. She was a retired teacher who was very active in her community and was an honorary police officer. Pamela was well liked and active. She lived with her husband and her younger son and his family lived close by.

10.20 Steven turned up at his parent's home. He said he wanted to stay with them in a small one-bedroom annex to the main house. Pamela was not happy about the situation and said they could only stay a short time. Things immediately became tense with Steven insisting on staying.

10.21 Steven was clearly a very self-focused, possibly narcissistic individual. He had been described as narcissistic and possibly personality disordered. He saw his mother as standing between him and his aspirations. In reality it was not simply Pamela standing in his way, but he fixated on her as the problem. Research reveals that in most cases of parricide the mother will be killed by a son.

10.22 It is also disclosed that Steven had a history of claiming rejection and abuse, not only when talking of his parents, but when talking of previous intimate relationships.

10.23 Steven was given access to a three bedroomed home that his parents had purchased for him, to live in with his family in Jersey. Steven also had a home in the UK. He refused to live in the three-bedroom home in Jersey and insisted on his plans for his parent's home being followed.

10.24 Steven refused to move out of the annex and a relentless and intense campaign began.

10.25 The relentless impact of the pressure, threats and manipulation cannot be over-stated. This pressure was put on Pamela in the main (as she was described by Steven as the main barrier to achieving his demands), Steven's father and his brother.

10.26 As things started to intensify, the risk to Pamela and others grew. Steven was attracting attention because of his mental health, but risk was seen to be confined to him until around July or August of 2019. Threats of suicide, in the context of coercive control and domestic abuse, are associated with homicide. As control intensifies and if there is a challenge or trigger – threats to suicide become even more strongly associated with homicide. The risk to Pamela and others was not fully seen by all professionals with the exception of the GP, until the eviction became imminent. Police recognised patterns of domestic abuse, as did the IDVA. Mental health services recognised an increasing problem and considered that Steven was a risk to others as the eviction became imminent. The GP recognised the escalating danger and spent many hours talking with Steven. He recognised the increasing problem with Steven's mental health and sought on many occasions to get support or help from mental health services. Pamela and her husband articulated that they were caught in an escalating risk predicament, but considered they were not receiving help or interventions that changed anything, or even reduced the distress and risk. Their focus was on mental health services, and they were reluctant to have criminal justice interventions.

10.27 There was acknowledgement from all professionals that everything was coming to a head with the threatened eviction of Steven from the annex.

10.28 The eviction was a trigger event. Threat of serious harm or homicide is typically preceded by a significant challenge to the control or perceived entitlements of a controlling person in the context of domestic abuse. The trigger will follow a pattern of abusive and controlling patterns. In this context, the trigger will provoke escalation in risk and then, if the situation seems irretrievable to the controlling person, they will decide on a resolution.

10.29 The escalation was recognised as a risk to others, though not necessarily specifically the heightened risk to Pamela.

10.30 As the eviction drew nearer and Steven's high-risk behaviours grew, the GP and the consultant psychiatrist attempted to detain Steven using the Mental Health Law. This was attempted on three occasions in fairly short amount of time. The first two attempts were postponed due to barriers created by Steven. At the third and final attempt, the authorised officer refused to allow the detention of Steven under mental health law, believing that the situation could be managed without detaining Steven.

10.31 The consultant psychiatrist, the GP, the specialist nurse and the police, attended Pamela's property where Steven was holed up in the annex to complete the detention under the Mental Health Law. Pamela and her husband were also there. Steven would only speak to people through a crack in the door of the annex. His partner and child were inside.

10.32 The authorised officer, a locum social worker, also attended as is necessary. An authorised officer makes the final decision around detention and whether the least intrusive intervention is being used. The authorised officer refused to allow the detention of Steven under the Mental Health Law. She considered that the situation could be managed without detaining Steven, but also considered that if the police were called a further time, then the detention could go ahead.

10.33 It seems possible that this decision was made without full knowledge of the antecedents in this case which raises an opportunity for learning in the future. We do not have the written notes of the decision and the authorised officer has not been available to contribute to this review.

10.34 This decision has been highlighted by several people involved as pivotal. The GP and the family expressed extreme frustration that the decision to detain was refused. The police expressed similar frustration.

10.35 It is possible that there could have been an escalation process started to override or challenge the decision of the authorised officer. It seems some professionals were unsure of the process to challenge the decision of the authorised officer.

10.36 Pamela was killed by Steven five days later in a determined attack. He took a knife with him to her home; he attacked her stabbing her in the neck and then blocked his father from administering first aid. He was determined that Pamela should die.

10.37 Given all the information gathered after the death of Pamela the risk escalation patterns became clearer. It is also accepted that all professionals, with the exception of the authorised officer, considered detention to be necessary given the identified risk to others.

10.38 This is in some ways a unique set of circumstances, but in other ways the patterns played out in a recognised way. It may be that hindsight helps us recognise the patterns more easily but

increasing knowledge of coercive control and domestic abuse risk patterns in professionals and with society more generally, can help identify escalating risk.

10.39 Organisations have looked at their own policies and practices and made recommendations for themselves. The GPs IMR is the most complete and considered analysis. There have also been improvements in policy and practice since the tragic death of Pamela.

11.0 Conclusions

The death of Pamela at the hands of her son was difficult to review, not just because of the terrible circumstances, but because of the complexity. This summary may also be difficult to read for professionals and the family. A DHR is a specific review that focuses on interpersonal dynamics and relationships and patterns of control and abuse in the antecedent history. This means there had to be a focus on Pamela, the happenings from her perspective and a move beyond Steven's mental health to identify patterns occurring in parallel.

The DHR did not focus on the detail of each professional interaction but focused more broadly on the way Steven's mental health diagnoses directed attention to the detriment of identifying known and established high-risk patterns that were operating in this case and typically occur in such homicides.

It is accepted that Steven's mental health, his rigid thinking patterns and his obsessions are relevant. Patterns of escalating risk as a result of coercive control and domestic abuse, however, can exist parallel with mental health conditions. They can happen in exactly the same way, whether or not there is ASD for example. In fact, mental illness diagnoses tend to exacerbate and increase risk to others in this context. Therefore, the analysis focus was broader, as it is possible that increasing knowledge of the risk patterns associated with domestic abuse and coercive control may create learning that will have more effect on future practice, than focus on individual actions. More knowledge of this pattern in all agencies may strengthen the decisions and approach in the future.

Steven's ASD on its own, did not necessarily stop him functioning in society. In fact, he had maintained a career as a consultant medical practitioner, albeit with some problems in his manner of communicating with people. Steven was also able to conduct intimate relationships and maintain friendships. Conversations with others, however, reveal that Steven had a history of considering himself a victim when he did not get his own way and accusing others of abusing him as a pattern. There is little doubt that he could also be manipulative, rigid and driven.

It was concluded that Steven was displaying patterns consistent with coercive control: he was forcing compliance with his demands on Pamela and his family and was subjugating her and them systematically, reducing their choices and their freedoms. Pamela was his primary focus, and he was fixated on her, manipulating her, violently abusing her, demeaning and isolating her. He dismissed her rights and freedoms and tried to convince others that she was a bad person. Pamela was subjected to a lot of abuse from Steven, and she found the situation intolerable, not just that he would physically hurt himself, but that he would physically hurt her or others. Her life in the months leading to her death was transformed as she tried to manage the growing threat. She was exhausted, traumatised and frustrated. She made great attempts to support Steven and his partner and child, she with her husband secured accommodation for them, she helped in the care of his partner and child, and she even went to therapy where she was maligned by Steven. The maligning of Pamela by Steven has continued after

her death, and this is a concern. Her death does not appear to have resolved any of the issues and those issues may still dominate Steven's thinking.

There are opportunities for learning when this situation is viewed through the lens of domestic abuse. This does not mean that Steven's mental health diagnoses are irrelevant, it means that in using the lens of domestic abuse, the threats and escalating risk to Pamela become clearer. The intervention of all organisations and their expertise could in future, be more effective if the dual lenses of mental health and domestic abuse are applied.

The conclusion is that the information was available, though not necessarily identified, that may have revealed the threat that was posed to Pamela.

12.0 Lessons to be learnt

Learning opportunity 1: Where there are clear mental health issues, this should not be assessed only through the lens of the impact on the individual diagnosed as suffering. Fuller consideration could be given to the impacts of their behaviours on those around them, especially in the context of risk.

Learning Opportunity 2: Where there are clear mental health problems other agencies could identify where they fit into the wider picture, rather than relying on mental health services as the only intervention. This is especially important where there is domestic abuse and where there are children.

Learning Opportunity 3: Mental health services could be more responsive to requests from other professionals to intervene, especially crisis interventions. Is there a process for crisis intervention? Do mental health services recognise the risks posed by controlling domestic abuse?

Learning Opportunity 4: Where there is a crisis identified by two professionals of sufficient standing and there is a Mental Health Law assessment, authorised officers should avail themselves of all information, especially around risk, given the power they have. Although the least intrusive intervention should be sought, this does not necessarily mean that an application for admission of a patient for assessment would not be the most appropriate and safe option. A full briefing should be sought considering the risk to others, especially in cases where there is domestic abuse.

Learning Opportunity 5: All professionals involved in a possible application for admission of a patient for assessment under the Mental Health Law should be advised of the escalation process by the authorised officer. Given the implications and power of their decision, others should be advised how they can challenge such a decision should they feel it urgent and necessary. This could be part of the role of the authorised officer.

Learning Opportunity 6: Training and awareness around patterns of coercive control and the way risk can escalate, should be a priority for all professionals. Mental health problems are known to potentially exacerbate risk in a domestic context and this knowledge may promote a more holistic assessment of risk. This is especially important for those professionals working in Multi-Agency Safeguarding Hubs.

Learning Opportunity 7: The role of the domestic abuse service and the IDVA should be promoted widely so that it is known by all professionals and the people of Jersey. Knowledge of domestic abuse and how it can escalate should be core knowledge. The advice of the domestic abuse service should always be sought and their inclusion in all safeguarding processes should be central.

Learning Opportunity 8: No professional should feel intimidated by mental health issues and the role of mental health services where they identify domestic abuse. Controlling patterns that are dangerous exist alongside mental health diagnoses. There is a safeguarding role in Children's Services, Social Work, Policing, Health Services and Domestic Abuse Services. Similarly, Mental Health Services should take a holistic view of the impacts of an individual's behavioural patterns and possible escalations in risk to others.

Learning Opportunity 9: It is possible that victims of domestic abuse may be unaware of coercive controlling patterns. Professionals, especially police and IDVA services could make victims aware of possible risks. Police could also always consider so-called 'victimless' prosecutions and their powers of arrest where behaviours are escalating to the extent they did in this case.

13.0 Recommendations

1. The proposed Domestic Abuse Law for Jersey must be prioritised to provide the necessary legal framework including definitions and a register of serious and repeat offenders to protect victims and bring perpetrators to justice.
2. The Safeguarding Partnership Board Domestic Abuse Strategy which is due for renewal in 2021 should reflect the key findings from this Domestic Homicide Review with updated programmes across prevention, protection and provision to reduce risk and improve measurable outcomes for victims.
3. The Safeguarding Partnership Board must promote a model of "Think Family" across the island/agencies to ensure the impact of behaviours and risk on wider family members is considered. Multi-agency models of assessment and support such as the Multi-agency Safeguarding Support Team (MASST), Community Adult Support Panel CASP and "Fresh Look" must bring together relevant professionals for joint assessment, planning and clear pathways into specialist services. The Safeguarding Partnership Board should review the scope and purpose of these forums to streamline decision making and improve outcomes.
4. The Safeguarding Partnership Board must seek assurance on effective multi-agency risk assessment, care planning, case co-ordination/management including use of the MARAC process with appropriate involvement of all relevant agencies.
5. Mental health services must review the pathway for crisis intervention, ensuring the views of professionals from other agencies are heard and considered when key decisions are being taken to manage risk. If as a result of difference of opinion between mental health professionals, a Mental Health Law assessment does not result in patient being placed under an Article of JMHL, they should seek advice from the relevant senior clinician as soon as feasible.
6. The Safeguarding Partnership Board should audit knowledge and delivery of the Resolving Professional Differences/Escalation Policy and foster a culture of constructive challenge in the interest of improving outcomes for people.
7. A programme of support and education for primary care teams to improve the safety, wellbeing and quality of life of survivors and victims of domestic abuse to be initiated. This could be based on the successful IRIS training and specialist referral pathway.
8. The Safeguarding Partnership Board should co-ordinate a communications programme to raise awareness to the public and professionals regarding domestic abuse including understanding coercive control. Promotion of the Independent Domestic Violence Advisor (IDVA) service and other specialist domestic services available on island will be part of the campaign.
9. The Safeguarding Partnership Board must audit and quality assure the multi-agency training provision for domestic abuse ensuring there is wide access, flexible delivery and consistent content reflecting the latest evidence on patterns of coercive control and is in line with the forthcoming Domestic Abuse Law for Jersey.
10. The States of Jersey Police should look to capitalise on the use of body worn cameras and capture other evidence which can be admitted under the res gestae[2] principle to support victimless prosecutions.

[2] *The phrase 'res gestae' which means a 'transaction' is used to describe a statement which relates to and is closely associated in time and place with a state of affairs or event so that it can be said that they form part of the 'same transaction'. An example is – spontaneous statements made by onlookers in response and at the same time as the commission of the offence.*

14.0 Appendix

Link to Court Judgement from 21st January 2021.

https://www.jerseylaw.je/judgments/unreported/Pages/[2021]JRC005.aspx