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Domestic Homicide Executive Summary

Gateshead Domestic Homicide Review Panel

Report into the death of
Adult A on 1st September 2011

Author: Mr Harry Stephenson

Independent Chair

DST Investigative Consultancy Services Ltd

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Executive Summary.

1. Introduction:

This Domestic Homicide Review (DHR) examines the circumstances surrounding the sudden unexplained death of Adult A in Gateshead. Northumbria Police were called to the report of a Missing Person on the 31st August 2011 (Adult A).

Adult B has pleaded guilty to the Murder of Adult A and sentenced to life imprisonment with a recommendation that he serves a minimum term of 17 years.

This Domestic Homicide Review has not found any evidence that there was any serious risk to the victim prior to death that should have been acted upon by any of the agencies. The review has identified a number of recommendations for improved practice; however none of these would have prevented the homicide.

2. The Review Process:

The purpose of a Domestic Homicide Review is to:

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

- Identify clearly what those lessons are both within and between agencies, and within what timescales they will be acted on, and what is expected to change as a result.

- Apply these lessons to service responses including changes to policies and procedures that are appropriate.

- Prevent homicide as a result of domestic violence and improve the response of services for all victims of domestic violence victims and their children through improved intra and inter-agency work.

The following specific areas are addressed in the Individual Management Reviews and Overview Report and are set out in the terms of reference for the Domestic Homicide Review

- A review of the circumstances leading up to the death of Adult A

- A chronological sequence of events from the 1st January 2010 up to and including the 1st September 2011.

- Engagement with the families of those involved and the neighbouring community to give them the opportunity to contribute to the review.

- A review of the actions of all the agencies involved with the families of Adult A and B and to establish whether there are any lessons to be learnt from

the case about the way in which local professionals and agencies work together to safeguard victims of domestic violence.

- Clear identification of what those lessons are, how they will be acted upon and what the expected change is as a result.

- Improvement where appropriate of any of the agencies policies and procedures relevant to these circumstances and the findings of the case.

- Liaison with the Police Senior Investigating Officer responsible for the criminal investigation to ensure that there was no compromise of the criminal investigation or the Domestic Homicide Review

Legal Enquiries and media enquiries were managed by Gateshead Council on behalf of the Community Safety Board.

The review also gave appropriate consideration to any equality and diversity issues that appeared pertinent to the victim or perpetrator e.g. age, disability, gender, race, religion and belief gender and sexual orientation.

The review considered any other information that was found to be relevant.

This summary outlines the process undertaken by the Gateshead Domestic Homicide Review Panel in reviewing the murder of Adult A. Criminal proceedings were completed on the 23rd March 2012.

The Gateshead Community Safety Board determined that a Domestic Homicide Review (DHR) was required in line with their policy and the Home Office Statutory Guidance for the Conduct of Domestic Homicide Reviews 2011.

The Home Office was informed of the intention to conduct a Domestic Homicide Review and the first review panel meeting was held on the 16th December 2011.

The process has been completed and the Overview Report, Executive Summary and Action Plan submitted to the Chair of the Gateshead Community Safety Board within the required six months timescale for the completion of the Domestic Homicide Review.

An initial meeting of all statutory agencies that potentially had any contact with Adult A took place on the 16th December 2011.

Agencies participating in this case review were:

- Northumbria Police
- Northumbria Probation Trust
- Gateshead Council
- Gateshead Housing Company

- NHS South of Tyne and Wear Serving Gateshead Primary Care Trust
- Gateshead Health NHS Foundation Trust
- HMP Durham
- Tyne and Wear Fire and Rescue Service
- Gateshead Age UK
- Gateshead Community Legal Advice Centre
- Family and friends

The agencies involved in the review were asked to give a chronological account of their contact with the victim Adult A and the perpetrator Adult B prior to the death of Adult A.

In line with the terms of reference the Domestic Homicide Review has covered in detail the period from 1st January 2010 until 1st September 2011. Each agency's report covers the following.

- A chronology of interaction with the victim and the perpetrator what was done or agreed;
- Whether internal procedures were followed; and conclusions and recommendations from the agency's point of view.

The following six agencies responded with information indicating some level of involvement with Adult A and Adult B:

- Northumbria Police
- Northumbria Probation Trust
- Gateshead Council
- Gateshead Housing Company
- NHS South of Tyne and Wear Serving Gateshead Primary Care Trust
- Gateshead Health NHS Foundation Trust

Contact with agencies:

As would be expected some of the accounts from the agencies involved on the review have more significance than others. The extent to which the key areas have been covered and the format in which they have been presented varies between agencies. The detail is clearly identified in the Overview Report and Individual Management Reviews.

Northumbria Police:

The Police report shows that they had no previous contact with the victim Adult A prior to him being reported missing from home on the 31st August 2011.

Adult B had not come to the notice of the police until his arrest on the 12th February 2010 for arson with intent to endanger life. Adult B did not come to the attention of the police again until his arrest on the 31st August 2011 for the murder of Adult A. The detail is clearly identified within the Overview Report and Individual Management Review.

Northumbria Probation Trust:

There were 10 identified contacts of interest with Adult B which deal with risk assessment, offender management, self-assessment and identification of personnel and financial difficulties. The detail is clearly identified within the Overview Report and Individual Management Review.

NHS South of Tyne and Wear Serving Gateshead Primary Care Trust and Gateshead Health NHS Foundation Trust:

There were 13 identified contacts between Adult A and his GP. These contacts related to attending routine appointments for medication reviews and assessment for Chronic Obstructive Airways Disease. The detail is clearly identified in the Overview Report and Individual Management Review.

There were 27 identified contacts between Adult B and his GP. These contacts related to attending medication reviews, cardiovascular review and general health checks. The detail is clearly identified in the Overview Report and Individual Management Review.

Parkinson's Disease Nurse Specialist:

There were a number of contacts between Adult A and the Parkinson's Disease Nurse Specialist which deal with his treatment and well being. The detail is clearly identified in the Overview Report and Individual management Review.

Physiotherapist:

There was one recorded contact with Adult A which deals with his treatment and well being. The detail is clearly identified in the Overview Report and Individual Management Review.

Gateshead Council:

Adult A had no contact with Financial Services.

There were two recorded contacts in respect of Adult B. These contacts relate to financial issues in respect of Council Tax arrears. The detail is clearly identified in the Overview Report and Individual Management Review.

Care Call was involved with Adult A's care during the period of this review. The detail is clearly identified in the Overview Report and Individual Management Review.

There was one contact recorded with Adult Social Care Direct in respect of Adult A this was in regard to the care of Adult A. The detail is clearly identified in the Overview Report and Individual Management Review.

There was one contact recorded with Occupational Therapy in respect of Adult A with regard to his well being. The detail is clearly identified in the Overview Report and Individual Management Review.

The Gateshead Housing Company:

Adult A had been a council house tenant for over 50 years who had not been of any concern to the service other than for matters related to general repairs and maintenance to his property. This contact is clearly identified in the Overview Report and Individual Management Review.

There was no contact with Adult B.

HMP Durham:

Adult B was held on remand at HMP Durham between the 13th February 2010 and the 16th July 2010, during which time he failed a mandatory drugs test. This contact is clearly identified in the Overview Report.

Tyne and Wear Fire and Rescue Service:

There was one recorded contact in respect of Adult A which deals with a fire safety home visit. This contact is clearly identified in the Overview Report.

Gateshead Age UK:

There were two recorded contacts in respect of Adult B with regard to advice and guidance. This contact is clearly identified in the Overview Report.

Gateshead Community Legal Advice Centre:

There were four recorded contacts in respect of Adult B with regard to financial matters. This contact is clearly identified in the Overview Report.

None of Adult A or B's contacts with the agencies prior to the death of Adult A was associated with a referral, assessment or any form of case management associated with domestic violence.

3. The Key Issues arising from the Review:

Having undertaken a detailed review of the circumstances related to these matters the following key issues have been identified.

Adult A was an elderly man who had lived at his home address since 1960. Adult A suffered a number of health issues including Chronic Obstructive Airways Disease and for 12 years had been diagnosed as suffering with Parkinson's disease.

In 2004 Adult B moved into the home address with Adult A.

No official notification of this move was ever given to the Local Authority, The Gateshead Housing Company or Adult B's GP. This could be perhaps identified as the start of the process of Adult A and Adult B's living arrangements never being communicated to any agency. The living arrangements were well known to neighbours but were accepted as being helpful to the care of Adult A.

The first time that it was identified that Adult B was living with Adult A was as a result of him giving Adult A's address on release from prison in July 2010. This was confirmed during a home visit by Northumbria Probation Trust following Adult B's release from prison.

Adult B first came to the notice of the agencies involved in the review as a result of financial matters relating to council tax arrears and an offence of arson with intent to endanger life which was motivated by financial reasons.

Following an arson attack at the home of other family members in February 2010 and the subsequent criminal investigation Northumbria Police made a decision not to refer Adult B into the Multi Agency Public Protection Agreement (MAPPA).

Adult B was a "Category 3 Offender" within the terms of Multi Agency Public Protection Arrangements; this review has highlighted the need for police officers to have a greater understanding of the process

Adult B was charged with arson with intent to endanger life, and at this point the involvement of Northumbria Probation Trusts commenced, at the pre sentence report stage. The risk assessment was set as low based on the offender's account of himself and his circumstances and the psychiatric report prepared by the defence.

In this case it appears that too much reliance was placed on the offender's self assessment report that led to a poor risk assessment.

During a routine health intervention by Gateshead Health NHS Foundation Trust in May 2010 Adult A did express some concerns in relation to Adult B who was on remand in prison for the offence of arson.

Consideration to refer into Adult Social Care Direct and Safeguarding in May 2010, in hindsight would have alerted the team of the potential risks associated with Adult B.

Whilst reviewing this particular case it was found that some of the records on the Carefirst system were not sufficiently explicit and could be open to interpretation and require further time consuming investigation. As a direct result of this review there will be staff briefings on accurate recording on the Carefirst system.

The Gateshead Housing Company followed their policy and procedure at the time of the arson attack with regard to the initial response.

However, following this action there is little evidence of any follow up activity by partners , discussions could have been held and the relevant information shared within the tasking and coordinating process.

A partnership discussion should have taken place about what needed to happen about the perpetrator. Arson incidents should be discussed by partners at tasking and coordination meetings.

During the course of the review it was established that none of the other partners involved in the management of the consequences of the arson attack made a referral to the tasking and coordinating process which resulted in a missed opportunity to share this information and consider action.

Adult B was on remand for the arson offence between 13th February 2010 and 16th July 2010. During his time in custody Adult B failed a mandatory drugs test.

It has been established that although the failure of the mandatory drug test is an illegal activity, the prison authorities deal with this as an internal disciplinary matter, rather than a clinical issue.

Any mandatory drug failure should be recorded on the prison medical records, but there appears to be no requirement to notify Adult B's GP on release from prison and the prison health records are retained by the prison. This would appear to have been a missed opportunity to share with other agencies information relating to Adult B.

4. Conclusions and Recommendations

This Domestic Homicide Review has not found any evidence that there was any serious risk to the victim prior to death that should have been acted upon by any of the agencies under their domestic violence policies or procedures.

What is perhaps important to identify is that from the information and research carried out during this Domestic Homicide Review neither Adult A nor Adult B had come to the notice of any of the Statutory or Voluntary agencies involved in this review for any matters until the offence of arson committed by Adult B in February 2010.

The police considered issues of domestic abuse at the time and in line with current procedures and definitions correctly determined that the circumstances did not fall within the domestic abuse arena.

It is also apparent from meetings with family, neighbours and friends involved in this review that they also had never expressed any concerns with regard to domestic violence in relation to Adult A or B.

In general each agency's involvement with the family was in the course of normal day to day business, and it is clear that the family were very private individuals who did not seek a great deal of assistance, but relied upon one another for support. This perhaps makes the death even more tragic and difficult for other family members to understand and to come to terms with.

The family members spoken to during this review did not feel that any agency could have provided any assistance that might have prevented the death and were satisfied with the contacts during the period identified by this review.

The review panel does consider that there were some missed opportunities for agencies to refer Adult B into the MAPPA process, share information, and pursue avenues of support for the family around such issues as finance and more specifically the arson offence; these missed opportunities are explored within the analysis section of this report.

The financial issues in respect of Adult B appear to have been common knowledge among neighbours and family and have been identified within the various agencies during their contacts with Adult A and B during the period of this review.

It is clear that the financial strain had a major impact on Adult B's life and well being and it was highlighted in the criminal case that the motive for the killing may well have been financial.

Financial difficulties can be a trigger for domestic violence, this DHR has identified that support was provided by a number of agencies in respect of Adults B's financial situation with nothing to indicate that as a result of this Adult A was in danger of suffering violence from Adult B.

Perhaps due to the fact that little was known about the family at that time and the way in which the perpetrator came over as being very compliant in his dealings with the agencies it created no obvious cause for concern.

What has come across during this review is the willingness of each agency to be very transparent, open and honest and a determination to learn from the experience and continue to make improvement.

The review has examined the domestic abuse services in Gateshead and concluded that the Gateshead Community Safety Board and Gateshead Domestic Abuse Executive Forum are very active in providing help and guidance in respect of domestic violence and appear to be effective.

The Domestic Abuse Executive Forum have continued to develop service user involvement and have a strong and robust service user group which meets regularly and works in partnership with a number of support agencies across Gateshead.

Each of the agencies involved in this DHR are active members and contributors to the partnership and have policies and procedures in place to deal with matters of domestic abuse which are the subject of regular review.

Details of all of the agencies together with help and guidance in respect of domestic abuse matters are contained in the document: "Gateshead Domestic Abuse Guide Service Director (March 2010) which also contains advice specific for men.

As a result of this Domestic Homicide Review into the death of Adult A. The Domestic Homicide Review Panel make the following recommendations: -

Recommendation 1 - Northumbria Police:

Training should be provided to officers to raise awareness regarding the identification of "Category 3 Offenders" and the procedure to refer them into Multi Public Protection Arrangements.

Recommendation 2 - Northumbria Probation Trust:

Policy and Procedures re Safeguarding Adults should be reviewed and re-issued. This is already agreed as part of the cycle of revision of policies. They would be issued as a mandatory reading for all staff on the Trust intranet.

Future risk management Training (mandatory for all staff) should include updated policy.

Recommendation 3 - NHS South of Tyne and Wear:

NHS South of Tyne and Wear and GP Consortia should ensure that the safeguarding adult's alerter training is included in the regular "Time in and Time Out" Events for GP practices.

Recommendation 4 - NHS South of Tyne and Wear:

The Safeguarding Vulnerable Adult – A Toolkit for GP's should be distributed to all GP's.

Recommendation 5 – Gateshead Health NHS Foundation Trust:

Gateshead Health NHS Foundation Trust should ensure that all health professionals have access to regular Safeguarding Adults Alerter training.

Recommendation 6 - Gateshead Council:

The Care Call annual visit process should be updated to enquire specifically who is living in the property with the client.

Recommendation 7 - Gateshead Council:

Confusion regarding Care Call records on the Carefirst system. When a new Care Call client is added to Carefirst should be investigated and anomalies resolved.

Recommendation 8 - Gateshead Council:

The partnership approach to responding to missing person's enquiries should be refreshed.

Recommendation 9 - The Gateshead Housing Company:

Anti Social Behaviour Investigation Officers should be updated on a victim centred approach and harm reduction.

Recommendation 10 -The Gateshead Housing Company:

Customer assessment tool training should be delivered for victims of Anti Social Behaviour victims and such assessments implemented into case management. This action was completed during the period of this Domestic Homicide Review.

Recommendation 11 -The Gateshead Housing Company:

Refresher training should be provided to the Neighbourhood Relations Officers investigating cases involving other tenures, including learning from case review and the need to take up police checks.

Recommendation 12 - The Gateshead Housing Company:

Case closure procedures by senior officers should be reviewed. This action has been completed during the period of this DHR and staff have been trained.

Recommendation 13 - The Gateshead Housing Company:

All arson incidents should be discussed by partners at tasking and coordination meetings.

Recommendation 14 – National:

Consideration should be given at national level to a review of the definition of Domestic Violence and criteria for a Domestic Homicide Review. The criteria for a Domestic Homicide Review includes the term "a person to whom he was related" which incorporates a much wider group of people and does not currently feature as part of the Domestic Violence definition – this appears to be an anomaly.

Recommendation 15 – HMP Durham:

HMP Durham to ensure that there is a robust transfer of appropriate health information to GPs on release.

There appears to be a gap in the sharing of relevant medical health information documented in medical records in prison. This should be shared with relevant agencies on or prior to the prisoner's release.

All of the recommendations from this review are clearly identified in the Action Plans and Overview Report.