Safer Gateshead

Safer People, Safer Communities

Domestic Homicide Overview Report – Executive Summary

An Independent Report concerning the Death of Cathy in 2014

Section 1 - Executive Summary – Cathy

1.01 Introduction

This Domestic Homicide Review was undertaken in relation to the death of a 42-year-old woman, Cathy, who was found strangled at the address of the perpetrator, Adult A. Adult A was sentenced on 29 June 2015 to Life Imprisonment.

1.02 Circumstances leading to Cathy's death

The relationship between Adult A and Cathy was unclear. It is presumed that over the previous 6 months they may have had an intimate relationship. Cathy also had an 'on/off' relationship with Adult B. At the time of her death, she used Adult A's address as a bail address, where she was 'electronically tagged' between the hours of midnight and 06.00hrs. It was believed that she was resuming her relationship with Adult B.

Cathy had been charged with an offence of Affray against her neighbour and first appeared in Court for this offence 20 October 2014. She was initially bailed to an address outside of Gateshead and unconnected to this review.

Cathy appeared before Gateshead Magistrates Court 12 November 2014 for breach of bail conditions. It was at this appearance that she was bailed to reside at the Address of Adult A with a curfew and an electronic tag. The monitoring equipment had been installed at the address of Adult A.

On 18th December 2014, Cathy applied to Crown Court to have her bail varied to allow her to sleep at her own home. The reasons for this application are unclear. Adult B said that he and Cathy intended to 'set up home together and settle down' and Cathy told her Solicitors that she planned to return home so that she could look after her brother who had long term physical health problems. The variation in bail was granted. At no time did Cathy's Solicitors say she was requesting a move to flee domestic violence.

The organisation responsible for moving the electronic monitoring equipment, EMS, were notified by Court of the change of circumstances at 17.41hrs on 18 December 2014. The contractual arrangements between EMS and the Ministry of Justice sets out the arrangements for moving the electronic monitoring equipment. If EMS are informed of bail variations before 15.00hrs, they will remove the equipment the same day. In relation to Cathy, they were notified at 17.41hrs and sent a Field Monitoring Officer to Cathy's address the next morning to install the equipment. By this point she had been murdered in the address of Adult A.

Cathy's understanding of where she had to return to on the night of 18 December 2014 is unclear. Adult B said that the Solicitor's Representative at Court told her to return to the address of Adult A. This is not substantiated. EMS informed the panel that they would not have reported her for failing to 'log in' at the address of Adult A because her bail conditions had been changed.

Cathy returned to the address of Adult A and the neighbours reported hearing a 'heated argument' at approximately 23.30hrs.

On Friday 19 December 2014, Adult A went to stay with his mother as he did each weekend. He had a black bin liner full of clothes and when he went out, his mother opened the bin liner and found what appeared to be a suicide note. Contained in the note were the words: 'she pushed me and I snapped'.

Adult A's mother contacted the Police. They attended his home and found Cathy's body. Adult A was reported missing and was later found at a Guesthouse in Leeds on 21 December 2014.

Adult A was arrested for the murder of Cathy. On 29 June 2015 Adult A was found guilty of Cathy's murder and sentenced to Life Imprisonment with a recommendation that he serves 12 years and 6 months.

1.03 The purpose of the Domestic Homicide Review

Domestic Homicide Reviews were established on a statutory basis under section 9 of the Domestic Violence, Crime and Victims Act 2004. A Gateshead Domestic Homicide Review Protocol has been developed using the revised statutory guidelines produced by the Home Office in August 2013 and has been endorsed by the Community Safety Board.

The Chair of Gateshead's Community Safety Board received formal notification from Northumbria Police of a domestic homicide within the borough. This information was received by the Chair on 6 January 2015 and Cathy's case was considered by the Community Safety Board on 16 January 2015 where the decision was taken that she should be subject to a Domestic Homicide Review

The purpose of a DHR 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, how 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 as appropriate

- Prevent domestic violence and abuse homicide and improve service responses for all domestic violence victims and their children through improved intra and inter-agency working

The aim of the review process is to make certain that victims of domestic violence and abuse are being dealt with appropriately by agencies in terms of arranging appropriate support mechanisms, resources and procedure to aim to prevent future incidents of domestic homicide and violence.

A review should also assess whether the agencies involved in the case have adequate and robust procedures and protocols in place and if so, were the procedures and protocols understood and followed by members of staff.

1.04 Local terms of reference

In addition to the aims of a DHR, local terms of reference were agreed:

- To what degree could the homicide have been accurately predicted and prevented?
- How effective were the MARAC arrangements to share information, understand the risks to the victim and prevent actual or potential abuse? Did all agencies comply with the MARAC Policy and Procedures? The relationship between the victim and perpetrator was not subject to MARAC procedures but given the victim's history should this have been raised and if so would it have made a difference?
- Both the victim and perpetrator misused substances, was there any link between drug use, the breakdown of the relationship and the homicide? Were all agencies fully aware of the impact of drug and the effects on the victim and perpetrator?
- Did all the agencies fully understand the nature of the relationship between the victim and the perpetrator and effectively assess any potential risk?
- Was the care, treatment and supervision provided to the perpetrator sufficient after his release from Prison and prior to the homicide?
- The perpetrator received care and treatment from Mental Health Services, was his care sufficient to meet his needs and were the risk assessments and risk management plans sufficient?
- What was the impact, if any, of the victim being tagged? Did agencies follow the Tagging Policy and Procedures and do these safeguard vulnerable people and those at risk of domestic violence? Does the Bail Act protect actual or potential victims?
- There are a number of agencies that have changed provider. Are there any concerns about the transfer of information to inform risk assessments and risk management plans? Did the new providers have all the relevant information to make judgements about risk?

1.05 Involvement of families

Cathy's mother was interviewed for the purpose of the Review and the Chair of the Panel remained in contact throughout the review. She believed the most important factor that contributed to her daughter's death was that she was 'electronically tagged'. If she had not been tagged she would not have been at Adult A's address. She did not believe that Cathy and Adult A were in a relationship at the time of her death, rather she was using his home as a bail address.

Adult A's mother and sister were also interviewed. They believe that Adult A was in a relationship with Cathy. The important factor for them was the decline in Adult A's mental health and they felt the support he received was inadequate.

Adult A declined to meet with the panel. Adult B was interviewed on the phone (his preferred method of contact) by the Chair of the Panel.

1.06 Agencies involved in the Review

The following agencies were asked to secure their records and prepare chronologies and Individual Management Reports (IMRs):

- Northumbria Police
- Northumbria Community Rehabilitation Company (CRC)
- National Probation Service North East (NPS)

- Gateshead Council
- NHS Newcastle Gateshead Clinical Commissioning Group (CCG)
- South Tyneside NHS Foundation Trust
- Gateshead Evolve
- North East Ambulance Service NHS Foundation Trust (NEAS)
- Gateshead Health Foundation Trust
- Northumberland Tyne and Wear NHS Foundation Trust (NTW)

Additional information was provided by:

- The Army in relation to the discharge of Adult A
- Cathy's Solicitors
- The Crown Prosecution Service
- Gateshead Housing Company

1.07 Panel Membership

Panel members were selected based on their seniority within relevant agencies and ability to direct resources to the review and to oversee implementation of review findings. Panel members were drawn from the following agencies:

- Independent Chair;
- Report Writer;
- Northumbria Police;
- Gateshead MBC;
- National Probation Service;
- Northumbria Community Rehabilitation Company;
- Gateshead NHS Health Foundation Trust;
- Clinical Commissioning Group;
- Northumberland, Tyne and Wear NHS Foundation Trust;
- Tyne and Wear Fire and Rescue Service;
- Providers of Treatment Services;
- Your Voice Counts (from March 2015);
- South Tyneside Foundation Trust (from March 2015);
- The Gateshead Housing Company (from March 2015);
- North East Ambulance Service (from March 2015);
- NHS England (from March 2015);
- HM Courts and Tribunals Service (from April 2015).

1.08 Timescales for the Review

The timescale for the IMRs was set between 1 May 2014 and 19 December 2014. If there was relevant information prior to the start of the IMR timescale this has been included by the relevant IMR report writers.

1.09 Summary of facts

Both Cathy and Adult A had a history of substance misuse and where known to GP and drug and alcohol services for their drug use. Adult A was not known to the Gateshead Drug and Alcohol Service, Evolve, at the time of the incident.

Both Cathy and Adult A had a history of offending behaviour. Cathy was charged with Affray at the time of her death and was on bail. Adult A had a long history of violent offences dating from 1994 to 2009. Agencies were aware that he had a violent history and had been in prison but were not aware of the nature or degree of the violence. Adult A had no convictions for domestic abuse. During the period of the review, Adult A was convicted for selling drugs to an off duty Police Officer. He received a 12 month Suspended Sentence Order for this offence 31 July 2014. This order was to be supervised by the Northumbria Community Rehabilitation Company (CRC).

Adult A was charged with assault against Adult B on 2 August 2014. It appeared that Cathy had returned to Adult B and was living with him. Adult A went to the address of Adult B and hit him over the head with a plank of wood. He was charged with assault and Cathy gave evidence to the Police.

What followed was a sequence of events in relation to Adult A and his appearance at Court. He did not attend the initial meeting on 5 August 2014 with CRC to commence supervision of his Suspended Sentence Order because he was on remand for the assault against Adult B. On 19 August 2014, Adult A was granted bail and then on the 16 October 2014 the case against Adult A was discontinued. Due to administrative errors, Adult A was not supervised during this time by CRC in accordance with the Suspended Sentence Order.

Cathy had a history of being in violent relationships and was known to MARAC in relation to Adult B. She was also referred to the IDVA Service but was discharged for non-attendance. Prior to Cathy's murder, Adult A was not known as a perpetrator of domestic violence in relation to Cathy or any other relationships.

Adult A was known to Mental Health Services. He had a previous in-patient admission following an episode where he appeared psychotic. His admission was short term and there appeared no psychotic symptoms on discharge. Adult A had a diagnosis of anxiety and obsessive compulsive disorder. He was treated by Mental Health Services until 2014 when he was discharged from services for non-engagement. Adult A admitted to using street diazepam and was failing to provide urine samples to test for drugs.

Adult A was seen by the Criminal Justice Liaison Service when he was charged with assault against Adult B August 2014. This was a brief assessment to confirm whether or not needed a further mental health assessment or other services. He was not judged to be psychotic and therefore there was no further action from Mental Health Services.

Adult A was referred back to Mental Health services by the GP in October 2014. The referral was declined on the grounds that his primary needs were considered to be drug use rather than mental health. This was challenged by the GP and Adult A was offered an appointment on 15 December 2014 which Adult A cancelled because it clashed with a GP appointment. He was offered a further appointment in January 2015 by which time he was remanded in Prison.

1.10 Findings

1.10.1 To what degree could the homicide have been accurately predicted and prevented?

The agencies involved with Cathy and Adult A were not aware they were in a relationship and there is a lack of clarity about the nature of their relationship at the time of Cathy's death. It may be that they perceived their relationship differently. Given this, it was not possible to predict or prevent Cathy's homicide. Even if agencies had been aware of the relationship, Adult A would have been considered a low risk as he had no convictions for domestic abuse nor were any concerns raised through MARAC.

Cathy was a repeat victim of domestic abuse and it would have been appropriate to scrutinise her relationships in relation to potential abuse. However, in contact with agencies, she only ever referred to Adult A as her cousin or friend.

1.10.2 How effective were the MARAC arrangements to share information, understand the risks to the victim and prevent actual or potential abuse? Did all agencies comply with the MARAC Policy and Procedures? The relationship between the victim and perpetrator was not subject to MARAC procedures but given the victim's history should this have been raised and if so would it have made a difference?

Cathy was not subject to MARAC procedures in relation to Adult A but she was in respect of Adult B. Given that she died in a domestic setting the panel felt it appropriate to scrutinise the MARAC arrangements in relation to Cathy.

Most agencies were aware of MARAC and attended meetings as appropriate. Some had less knowledge e.g. the Private Rented Housing Team and others had less capacity to attend meetings e.g. The North East Ambulance Service. Most agencies provided training and had a system of alerts on individual peoples' records to flag concerns regarding domestic abuse.

Cathy was discussed a number of times under MARAC and her house was made a Police Area Command priority in October 2014 in relation to Adult B. A number of police visits were made and at the time Cathy was separated from Adult B. Adult B was arrested a number of times and a restraining order applied for. Northumbria Police pursued a victimless prosecution against Adult B for an assault on Cathy following her death.

Cathy was known to the IDVA service but discharged following nonattendance at appointments.

To conclude, the panel felt that the MARAC procedures were applied appropriately to Cathy. Most agencies were aware of the concerns and there were opportunities for Cathy to engage with services. Her lack of engagement with the IDVA service was discussed and it was agreed that there needs to be a more assertive approach to people like Cathy. The development of the Multi-Agency Safeguarding Hub

(MASH) is seen as positive, the purpose of this team is to work with vulnerable people who are at risk, to develop an assertive approach to engaging with such people.

There was a missed opportunity in relation to the assault by Adult A on Adult B. This was seen as a violent assault by one man against another. It was not considered a domestic violence offence even though it occurred as a result of the complex relationship between the three people. If this had been considered differently, agencies may have been alerted to concerns regarding the potential for violent behaviour.

1.10.3 Both the victim and perpetrator misused substances, was there any link between drug use, the breakdown of the relationship and the homicide? Were all agencies fully aware of the impact of drug and the effects on the victim and perpetrator?

Both Cathy and Adult A had a history of drug use, both were prescribed methadone in accordance with NICE guidelines. There was evidence of information sharing between agencies.

It is not known if either Adult A or Cathy were under the influence of drugs or alcohol at the time of her death. However, there was evidence that Adult A's drug use was increasing during the months leading to the incident e.g. he said that he was getting street diazepam from Cathy and he was convicted of a drug related offence. Cathy's drug use appeared stable. At the time of her death she was known to the drug and Alcohol treatment service, Evolve. Cathy was however not compliant with treatment and she would miss appointments.

It was a finding of the panel that drug and alcohol services would often work in isolation from other services. Where people have complex and multiple issues such as Cathy and Adult A there is a strong argument for a multi-agency approach such as the MASH.

1.10.4 Did all the agencies fully understand the nature of the relationship between the victim and the perpetrator and effectively assess any potential risk?

None of the agencies were aware of the relationship between Adult A and Cathy. Adult A informed his mental health worker that he was in a relationship but that it had ended. There were missed opportunities to ask about their relationship as they were seen together on some, but not many, occasions e.g. by the CPN, Evolve. Given that Cathy was a repeat victim of domestic violence all agencies should be alert to relationships and the potential for further violence.

The assault by Adult A on Adult B was a missed opportunity to explore the relationship between the three people and consider risk. However, this was seen as an assault by one man against another, not a domestic violence incident.

There is evidence, from his family, that Adult A did not cope well with the break-up of relationships but this is with hindsight.

1.10.5 Was the care, treatment and supervision provided to the perpetrator sufficient after his release from Prison and prior to the homicide?

Adult A was not supervised after he was released from prison on 19 August 2014 following a Judge in Chambers decision. He was not supervised by CRC because of administrative errors and he was initially bailed to his mother's address.
There is evidence that his drug use had increased during the months before the incident and the GP reported a decline in his mental health. He was referred to Mental Health Services but the referral was not initially accepted. During this period, Adult A was seen by the GP but no specialist mental health or offender management service. There was no up-to-date risk assessment completed nor a risk management plan.

It is difficult to know whether or not appropriate supervision may have prevented Cathy's death but it is significant that as Adult A's needs appeared to be increasing he had less supervision.

1.10.6 The perpetrator received care and treatment from Mental Health Services, was his care sufficient to meet his needs and were the risk assessments and risk management plans sufficient?

Adult A had a long history of contact with Mental Health Services. He has a diagnosis of Obsessive Compulsive Disorder and Anxiety and was prescribed psychiatric medication. There was evidence that Adult A had responded to mental health treatment however at the beginning of 2014 he appeared to be disengaging. Adult A's drug use was increasing which may have contributed to his disengagement.

Northumbria, Tyne and Wear Mental Health Trust (NTW) have a Dual Diagnosis Policy and applied NICE Guidelines to the care and treatment of Adult A. It was believed that Adult A was not able to engage in therapeutic services because of his increased drug use. However, this is common with people with dual diagnosis and consideration should be given to an assertive approach to people with mental health problems and drug use.

Adult A was re-referred to Mental Health services by the GP shortly before the incident. This referral was initially not accepted because it was believed that his primary problem was drug use albeit there had been significant changes in his circumstances e.g. assault on Adult B. It has been agreed that there needs to be more discussion between referrer and Mental Health Services.

1.10.7 What was the impact, if any, of the victim being tagged? Did agencies follow the Tagging Policy and Procedures and do these safeguard vulnerable people and those at risk of domestic violence? Does the Bail Act protect actual or potential victims?

Cathy was electronically tagged as part of her bail conditions with a curfew between midnight and 06.00hrs. On 18 December 2014 she applied to the Crown Court to have her bail conditions varied so that she could return to her own address. The

equipment was to be installed at her own address the following morning. Cathy returned to the address of Adult A where she was murdered.

It was unclear what information Cathy was given about where she should go that night. She would not have been in breach of her bail if she had returned to her own address as the bail had been varied although the monitoring equipment had not been moved. Adult B said that the person who worked for the Solicitors said that she should return to the address of Adult A. The solicitor's representative cannot recall this conversation.

Cathy's mother believes that this is the most important factor that contributed to Cathy's death, that is: if she had not been there, she would not have been killed.

It is difficult to understand the processes around electronic tagging. There is guidance to say that repeat victims of domestic violence should not be tagged because it reduces their freedom of movement. However, this is in relation to where victims are tagged to an address where they are considered a risk. Cathy was not considered a risk from Adult A.

The panel considered whether or not repeat victims of domestic abuse should be electronically tagged at all. However, if this Court disposal was unavailable it may restrict options for repeat victims, they may be more likely to be remanded which is not appropriate.

What was evident was the need to give clearer instructions to people who are electronically tagged. If Cathy had been informed that she could have returned to her own home, would she have done so?

1.10.8 There are a number of agencies that have changed provider. Are there any concerns about the transfer of information to inform risk assessments and risk management plans? Did the new providers have all the relevant information to make judgements about risk?

There were two changes of provider. In terms of Drug Treatment Services, this was transferred from South Tyneside NHS Foundation Trust (STNHSFT) to Evolve. There were issues of transfer of information but this did not impact directly on the incident.

The second change of provider was in relation to offender management services. The National Probation Trust split in July 2014 between Northumbria Community Rehabilitation Company (CRC) and National Probation Service (NPS).

The NPS dealt with Adult A's court appearances but he was supervised by CRC for his Suspended Sentence Order (from 31 July 2014).

Both organisations share the same electronic recording system, nDelius. During the months leading up to the incident there were many changes in relation to Adult A's legal status e.g. on remand for the assault against Adult B, on bail via a Judge in Chambers decision (19 August 2014) and then the case was discontinued (16

October 2014). Effectively Adult A was back in the community from 19 August 2014 but he was not supervised by CRC during this time.

This error was attributed to recording systems between NPS and CRC. NPS accurately recorded Adult A's change in status on nDelius but this was not picked up by CRC because of the lack of use of the 'Alert' function on the electronic system. When case recordings are made, the author can elect to 'alert' the Offender Manager to the new entry via the 'Alert' function. Within both organisations there was a lack of clarity about how to use this. Some workers apply it to all entries, others apply discretion. If overused it 'blocks' the electronic system. Clearly there needs to be guidance about the effective use of this function. Offender Managers work with high caseloads and cannot be expected to read all entries and therefore it is appropriate to be 'alerted' to significant events. However, this error resulted in Adult A not being supervised prior to the incident.

1.11 Conclusions and recommendations

It was the conclusion of the panel that Cathy's death could not have been predicted or prevented because it was not known that the couple were or had an intimate relationship. Even if agencies had known, Adult A would most likely have been considered a low risk violence to others in a domestic setting.

Cathy was a repeat victim of domestic abuse and the MARAC procedures had been used effectively. However, more needs to be done to work with people who dis-engage from services and who have multiple needs. It is hoped that the development of the Multi-Agency Safeguarding Hub (MASH) will resolve this. This multi-agency team will work with people identified as the most vulnerable, it will take an assertive approach and communication between agencies will be improved.

Cathy was bailed and electronically tagged to sleep at Adult A's address until the day of the incident when her bail conditions where changed for her to return to her home address. She returned to the address of Adult A that night presumably because she believed she had to until the monitoring equipment had been installed in her own address. Clearer direction need to be given to people in these circumstances.

Whilst Cathy's death could not have been prevented there are lessons to be learnt and recommendations for changes in practice. All of the recommendations are identified in the Action Plan, some are specific to individual agencies but consideration here is given to the overarching recommendations.

The full and detailed recommendations are contained within the Overview Report and below is a summary:

1.11.1 Recommendation 1:

All agencies need to ensure that their workers understand about MARAC and can contribute to the process. Agencies need to identify the appropriate training for their service area.

1.11.2 Recommendation 2:
All agencies need a system of accurately recording who is subject to MARAC procedures so it 'flags' up those at risk.

1.11.3 Recommendation 3:
Consideration should be given to the appropriateness of 'electronically tagging' repeat victims of domestic abuse.

Where people are electronically tagged and there is a variation in their address but the electronic monitoring system has not yet been installed in the new address, The Ministry of Justice should provide guidance to the Courts and Solicitors on who has the responsibility of informing the person where they should reside in these circumstances.

1.11.4 Recommendation 4:
There needs to be policy decisions and training about how the 'Alert' function is used on the Offender Management system nDelius to ensure that significant information is communicated effectively.

1.11.5 Recommendation 5:
Relevant policies shared by NPS and CRC need to be updated to reflect the changes in the provider services e.g. Judge in Chamber Policy.

1.11.6 Recommendation 6:
There needs to be a more assertive approach to engage and work with victims of domestic violence, particularly when they may be repeat victims of violence, have multiple issues and be repeat non-attenders at support services. The development of the MASH should meet this recommendation.

1.11.7 Recommendation 7:
Drug and alcohol are major factors in domestic violence and each agency should ensure their services link with drug and alcohol services and there is clear information.

1.11.8 Recommendation 8:
When a person is referred to Mental Health Services and the referral is rejected, there should be a discussion between the agencies to clarify the concerns and either re-consider the referral or discuss other options.