A Domestic Homicide Review into the Death of Adult A

A report for the Safer Cornwall Partnership

Author: Martine Cotter MCMI

December 2013

I would like to express my sincere condolences to the family and friends of Adult A.

My gratitude is also extended to the professionals, agencies and panel members who dedicated their time, commitment and tenacious attention to detail throughout the Domestic Homicide Review.

Martine Cotter

Independent Chair 2013

The names of individuals have been changed to protect identity

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SECTION ONE

SECTION ONE: INTRODUCTION AND BACKGROUND

Introduction

1) At 0218am hours on the morning of the17th April 2012 Police were called by Ambulance control to attend (REDACTED ADDRESS). They had been contacted by C1, the eldest son of Adult A to advise that Adult A was on the floor of his lounge, apparently having been assaulted by Adult A's grandson, Adult B.

2) C1 had been alerted via Adult A's Lifeline alarm, informing him that Adult A needed assistance. Upon attending C1 found Adult A prone on the floor. Adult A was conscious and told C1 that Adult B had entered the flat with a key at around 0100am, grabbed him around the throat and thrown him to the floor. It was discovered that £300 had been removed from Adult A's wallet. Adult A complained of pain to his neck and ribs and as such, C1 did not attempt to move him and called the Ambulance Service.

3) Adult A was conveyed to (REDACTED HOSPITAL) where staff assessed and treated his injuries. On the afternoon of the 20th April 2012, as Adult A was returning from a CT scan, he went into cardiac arrest. The 'Crash Team' carried out immediate CPR but Adult A was pronounced dead at 1333 hours.

4) Adult B was convicted of murder and robbery on the 1st July 2013 at (REDACTED) Crown Court. He was sentenced to life imprisonment with a minimum tariff of 15 years.

Reasons for Conducting the Review

5) Domestic Homicide Reviews (DHRs) came into force on the 13th April 2011. They were established on a statutory basis under Section 9(3) of the Domestic Violence, Crime and Victims Act (2004). The act states that a DHR should review 'the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by—

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

   (b) A member of the same household as himself, held with a view to identifying the lessons to be learnt from the death'

6) Adult A was the biological grandfather of Adult B therefore Safer Cornwall concluded that the death of Adult A met the criteria for a DHR and commissioned a review in consultation with partners in line with the Home Office Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews (2011) with the purpose of:

   - Establishing what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations worked or work, individually and together to safeguard victims;

   - Identifying 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;

   - Applying these lessons to service responses including changes to policies and procedures as appropriate;

   - Identifying what needs to change in order to reduce the risk of such tragedies happening in the future;

- Improve service responses for all domestic abuse victims through improved intra and inter-agency working.

Scope of Review

7) ***The Victim***

8) The Review Panel learnt that Adult A received an assessment by Adult Social Care and Support in 2011 which included an assessment of his safety and risk. To ensure this information was examined, the Panel secured records in the county of Cornwall from **1st January 2011** up to the date of Adult A's death on **20th April 2012.**

9) ***The Perpetrator***

10) During the criminal investigation, the Review Panel was informed that Adult B was referred for a mental health assessment in 2010 following concerns about a possible psychotic episode. The Panel wished to understand the earlier history of Adult B to determine whether the referral to Mental Health Services was an accumulation of ill health or a one-off event.

11) Applying the principle of thoroughness, the Panel wished to establish whether any early warning signs or opportunities existed in Adult B's past for professional intervention which might have had a bearing on his behaviour and subsequent actions on the 17th April 2012 that led to Adult A's death.

12) The Domestic Homicide Panel decided to review agency contact with Adult B from the 1st January 1992 up to the date of the attack on Adult A on the 17th April 2012, unless it became apparent that the timescale in relation to some aspect of the review should be extended or reduced.

13) No records provided by individual agencies involved with Adult B during his earlier years suggested an escalation of concerns emanating from his childhood. Therefore the Chair amended the scope of the review to focus on agency contact with Adult B from the **1st January 2010** up to the date of the attack on Adult A on

the **17th April 2012.**

Terms of Reference

14) The following areas are addressed within this overview report;

15) A review of the actions of the agencies involved with Adult A and Adult B and any other relevant agencies or individuals;

16) An assessment of whether the incident in which Adult A died was a 'one off' or whether there were any warning signs that would indicate that more could have been done in Cornwall to raise awareness of services available to victims and perpetrators of domestic abuse;

17) An assessment of whether family, friends, key workers or colleagues (including employers) were aware of any abusive or concerning behaviour from the perpetrator to the victim (or other persons);

18) A review of any barriers experienced by the family/friends/colleagues in reporting any abuse or concerns in Cornwall or elsewhere, including whether they (or the victim) knew how to report domestic abuse had they wanted to;

19) An assessment of whether there were opportunities for professionals to enquire or raise concerns about domestic abuse in the family;

20) A review of any previous concerning conduct or a history of abusive behaviour from the perpetrator and whether this was known to any agencies;

21) An evaluation of any training or awareness raising requirements that are necessary to ensure a greater knowledge and understanding of domestic abuse processes and / or services in the county.

22) Consideration of any equality and diversity issues that appear pertinent to the victim, perpetrator or family members e.g. age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex and sexual orientation.

23) Any other information that is found to be relevant.

24) The Review excludes consideration of how Adult A died or who was culpable.

25) The Terms of Reference have been shared with key family members of Adult A and Adult B.

The Independent Chair

26) The Safer Cornwall Partnership on behalf of Cornwall Council, commissioned Martine Cotter as Independent Chair to undertake this external review.

27) It is the responsibility of the Independent Chair in consultation with the Panel to:

- Conduct the review in accordance with the Terms of Reference and Provisional Review Framework;

- Prepare this Overview Report for Safer Cornwall.

28) The Independent Chair has liaised (and will continue to communicate) with the Domestic & Sexual Violence Strategy Manager on all matters including the process of publication of this report. The Independent Chair is responsible for the final overview report and its summary.

29) Martine Cotter is a qualified strategic manager and a member of the Chartered Institute of Management with over 11 years' experience in the field of domestic abuse and sexual violence. Martine was the former Chief Executive of a specialist charity and was instrumental in developing the first Sexual Assault

Referral Centre (SARC) in the Southwest. From 2009 - 2011, Martine was seconded to the Department of Health's National Support Team for the Response to Sexual Violence as a Sessional Adviser. In 2010 Martine completed the DASH 'Train the Trainers' Master Class and has since delivered Domestic Abuse training to more than 2700 frontline professionals throughout the UK, including Early Years, Third Sector, Social Services, Housing, Education, Armed Forces, Mental Health and Criminal Justice Agencies. Martine is the Independent Chair of four Domestic Homicide Reviews (at the time of this report).

Review Panel

30) The primary responsibilities of the panel of professional advisers include;

a. Reviewing the Individual Management Reports
b. Summarising concisely the relevant chronology of events including the actions of all the involved agencies;
c. Analysing and commenting on the appropriateness of actions taken;
d. Making recommendations which, if implemented, will better safeguard victims of domestic violence in the future;

31) The panel of professional advisers have been sourced according to the specific modus operandi of the homicide. Core members include;

(Table 31a)

Representative of	**Occupation/Professional Management Status**
Safer Cornwall	Domestic and Sexual Violence Strategy Manager
Devon and Cornwall Constabulary	Public Protection Unit Lead for Cornwall

Community Safety & Protection	Community Safety Manager
NHS Kernow (Clinical Commissioning Group)	Head of Strategic Communications
Cornwall Foundation Trust	Adult Safeguarding Lead Professional
Children's Social Care	Senior Manager Children's Social Work & Psychology Service
Children's Schools & Families	Deputy Safeguarding Children Manager & Local Authority Designated Officer
Children's Schools & Families	Principal Education Welfare Officer
Devon & Cornwall Probation Trust	Senior Probation Officer (REDACTED) and Falmouth) and Quality Development Manager for Cornwall.
Specialist Voluntary Sector	Manager of Independent Domestic Violence Advisors (IDVAs) – Cornwall & Isles of Scilly
Drug Alcohol Action Team (DAAT)	DAAT Manager

Statement of Independence

32) Independence and impartiality are fundamental principles of Domestic Homicide Reviews. The ethical principles and impartiality of the Independent Chair, Review Panel and IMR Authors are essential elements to protect the quality, legitimacy and credibility of the review and subsequent overview report.

33) The Independent Chair, panel members and IMR authors were asked to disclose or declare any matters that could affect their impartiality or that could reasonably

be perceived to do so, and any other matters that might be of interest for transparency purposes. No such declarations were made.

34) The Chair certified that she had no connections or ties of a personal or professional nature with the family or any participating organisation at the time of the review which would affect a fully independent judgement regarding the outcomes of the review, in either a positive or negative sense.

35) The panel members and IMR authors were appointed based on their independence, having had no previous connection or tie to the family or any responsibility for direct line management of any member of staff involved with the case over the past 5 years.

Guiding Principles for Panel and Review

36) The review panel were committed to the ethos of equality, openness, and transparency. There was no suspicion of concealment and all factors were thoroughly considered with an objective, open-minded, impartial and independent view. Due regard was paid to confidentiality and the balance of individual rights and the public interest.

37) The Review Panel sought to involve family and friends to participate in the review and approached this with sensitivity, compassion, patience and respect. No employer was approached as this was not applicable in this case.

38) The Review Panel gave appropriate consideration to any equality and diversity issues in line with the Equality Act 2010 that appeared pertinent to the victim, perpetrator or family members e.g. age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex and sexual orientation.

Panel Meetings

39) The first Review Panel was scheduled on the 7th September 2012 to review secured records.

The Domestic Homicide Review Panel met on four further occasions;

- 17th December 2013
- 30th January 2013
- 15th March 2014

Full minutes were recorded for all meetings

Timescales

40) The Home Office was informed of the intention to conduct a DHR on the 31 July 2012. This was within 2 months of being notified of the domestic homicide (20 April 2012).

41) The Statutory Guidance for Conducting Domestic Homicide Reviews (March 2011) recommends that the Overview Report should be completed, where possible, within 6 months of the commencement of the Domestic Homicide Review (not including any judicial investigation and court proceedings)

42) On advice from the Senior Investigating Officer, the Review Panel deemed it necessary to temporarily delay the Overview Report until the conclusion of the criminal case. In this situation all relevant agencies were notified of the requirement to secure records pertaining to the homicide against loss and interference.

43) The Independent Chair and Panel of Advisers ensured all records were reviewed and a chronology drawn up to identify immediate lessons to be learnt. All early lessons were shared with the relevant agencies for action and secured for the subsequent Overview Report.

44) Table 45a (below) sets out the original timescale for the completion of the DHR as stated within the full Terms of Reference;

Table 45a

ACTION	ACHIEVE BY
Request for IMRs	21.09.12
1st Draft of IMRs completed	07.12.12
1st Panel Meeting to Review IMRs	17.12.13
Clarifications/Questions/Family Participation	11.01.13
Panel Meeting to conclude and agree chronology	30.01.13
1st Draft Overview Report completed	18.03.13
Panel Meeting to Review Overview Report	22.03.13

45) Unfortunately the timescale for completing the Domestic Homicide Review was significantly delayed by a number of unexpected factors;

- A request to grant IMR authors with an extension for 1st draft submissions;
- A delay in obtaining a license for the ChronoLator Programme;
- The deferral of the criminal justice trial to the 24th June 2013;
- A delay in contacting Adult B due to medical treatment received in prison;
- Receipt of notification of 3 DHRs within 2 months of the statutory duty to undertake the process, creating significant resource issues to be able to identify IMR authors and an accredited Independent Chair;
- A delay in receiving medical information from the prison service.

46) The Review Panel anticipate that the Overview Report will be completed by November 2014, twenty months after the original timescale was set and seventeen months after the conclusion of the trial. The Review Panel is extremely apologetic for the delay and aim to complete the Overview Report in the earliest possible time, without compromising quality.

Methodology

47) This Review was guided by:

- The key processes outlined in the Home Office Multi Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews (2011);

- A guide for the Police, Crown Prosecution Service and Local Safeguarding Children's Board to assist with the Liaison and the Exchange of Information when there are simultaneous Chapter 8 Serious Case Reviews and Criminal Proceedings (April 2011);

- Learning from other Domestic Homicide Reviews and Serious Case Reviews of child/vulnerable adult deaths across the UK;

- The cross-government definition of domestic abuse (March 2013);

  Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass but is not limited to the following types of abuse:

  - *psychological*
  - *physical*
  - *sexual*
  - *financial*
  - *emotional*

48) The Review comprised of a thorough examination of all relevant information including documentation provided by the criminal justice investigation (including key witness statements), individual professionals, commissioners and agencies.

49) Twenty six (26) Professionals were interviewed from five different organisations.

50) The Domestic Homicide Review has no legal sanction or power to enforce a request made by the Review Panel or Chair that an individual attend for an interview.

51) The Review Panel did not need to seek the expert advice or opinion of any other specialist during the review as all questions were answered by members of the Review Panel or the original authors of the Individual Management Reviews.

52) The views and conclusions contained within this overview report are based on findings from both documentary evidence and some interview testimony and have been formed to the best of the Review Panel's knowledge and belief.

Family involvement

53) The Review Panel invited the family members of Adult A and Adult B to participate in the review. The family dynamics were sensitive as family members were related to one another as consanguinity. The Panel was told that the homicide had divided the family into two alliances.

54) On advice from the Senior Investigating Officer the Review Panel did not make contact with the families until the conclusion of the trial. On reflection, and following Home Office training in April 2013, the Review Panel now understand that this was a missed opportunity for the family to be involved with the Domestic Homicide Review from the outset.

55) The Review Panel accept responsibility for this decision; which conflicted with Statutory Guidance for Conducting Domestic Homicide Reviews (2011) and the Terms of Reference for involving family members, at the time. This is a matter of regret for the Review Panel but also an opportunity to learn for future Domestic Homicide Reviews.

56) On conclusion of the trial, the DHR Chair contacted each member of the immediate family through Adult A's four sons. One son (and associated family)

from each 'alliance' agreed to participate in the review. The family members representing Adult A (C3 and his wife) are referred to as **F3** and the family members supporting Adult B (C4, C4a and C4b) are represented as **F4**.

57) The Chair and Domestic and Sexual Violence Strategy Manager arranged to meet Family 3 at the family home on the 27th August 2013 and Family 4 on the 25th August 2013 at an undisclosed address.

58) The Review has incorporated the comments, views and suggestions from Family 3 and Family 4 within Section Three of the Overview Report (Analysis of Family and Friends Witness Statements).

59) It should be noted that two of Adult A's sons were too ill to participate. These relatives asked for Family 3 to represent them and asked for all information to be shared through C3.

60) To assist with producing a balanced Overview Report, the Independent Chair wished to invite Adult B to participate in the Domestic Homicide Review. An approach was made through the family, however, the Chair was informed that Adult B was about to embark on a 12 month therapy programme, which would not be conducive to his participation. A further approach was made through Probation Services but no response was received. In the absence of Adult B's participation, the Independent Chair reviewed his police interviews and defence testimony presented during the criminal justice trial.

61) In the absence of participants representing the views and experiences of friends and work colleagues, the Review Panel included an analysis of witness statements obtained as part of the criminal justice investigation. This information was shared in the public interest under the prevention of crime and disorder.

Confidentiality

62) The Independent Chair and Expert Panel observed strict rules of confidentiality with regard to all information that came to their attention in connection with the Domestic Homicide Review insofar as confidentiality could reasonably be maintained.

Disclosure of Records

63) During the criminal investigation, Adult B denied access to his medical records which created an ethical challenge for the Domestic Homicide Review and in particularly for the IMR author writing on behalf of the Cornwall and Isles of Scilly Primary Care Trust.

64) The Review Panel sought guidance from previous Domestic Homicide Reviews and referred to the *Sheffield First Domestic Homicide Overview Report produced by Professor Pat Cantrill (December 2011).* Professor Cantrill obtained legal opinion and a supporting statement from the General Medical Council; which stated that:

> *We (the General Medical Council) feel that there is a strong parallel with Serious Case Reviews. Our 0-18 years guidance for doctors (paragraph 62) says that doctors "should participate fully" in Serious Case Reviews;* it goes on to say *"When the overall purpose of a review is to protect other children or young people from a risk of serious harm, you should share relevant information, even when a child or young person or their parents do not consent." We think it reasonable that this should be the principle that doctors should follow in cooperating with DHRs as well".*

65) To further reassure health agencies, particularly general practitioners, the Sheffield First Review Panel developed a guidance document which was adopted by the Safer Cornwall Partnership and circulated to the IMR Authors on behalf of this Domestic Homicide Review. It is the understanding of the Review Panel that this document has been acknowledged by the General Medical Council.

66) Safer Cornwall would like to express thanks to Professor Cantrill and her Review Panel for seeking national guidance and legal advice on accessing medical records (without consent). The guidance document and accompanying statement from the General Medical Council undoubtedly helped to overcome the challenge of access to Adult B's medical records as part of this Domestic Homicide Review.

Requests to Secure Information

67) To ensure that early lessons were not missed, the panel decided that the DHR should not be delayed by pending legal action against Adult B and sought to notify agencies and interested parties of the requirement to secure records pertaining to the homicide to inform the subsequent Overview Report. Each agency was asked to contact the Independent Chair outlining the nature of the contact with the family.

68) The agencies asked to secure information are listed in table 69) below. Agencies highlighted in red confirmed that they held information relevant to the DHR. The remaining agencies (not highlighted in red) did not hold any information relevant to Adult A or Adult B;

69) Table

County/Area	Agency/Professional
Cornwall	Lifeline
	Hartley Care Services
	Supported Housing
	Devon and Cornwall Police
	Cornwall & IoS Primary Care Trust
	Drug and Alcohol Service
	Anti-Social Behaviour Team
	Children's Social Care

	Education and Welfare Department
	Adult Social Care
	Cornwall Foundation Trust – Mental Health Services
	Safer Cornwall
	Devon and Cornwall Probation Trust

70) Letters were sent to all participants thanking them for their contribution. Agencies that *did not* hold information were informed that an Individual Management Review would *not* be required. Agencies *with* relevant information were notified in writing of a request to undertake an Individual Management Review (IMR) under Section 9 of the Domestic Violence, Crime and Victims Act 2004. Correspondence included;

- A Guide for Appointing an IMR Author *
- An IMR Author's Guide *
- An IMR Template and Guidance for completing an IMR *
- A copy of the Terms of Reference

❖ These documents are available on request.

Commissioning of Individual Management Reviews (IMR)

71) The aim of an Individual Management Review is to look openly and critically at individual and organisational practice to see whether the case indicates that changes could and should be made and, if so, to identify how those changes will be implemented.

72) An IMR report should provide a chronology of agency involvement and bring together and draw an overall conclusion from the involvement of the agency with Adult A or Adult B.

73) The findings from the IMR report should be endorsed and quality assured by the senior officer within the organisation who commissioned the report and who will be responsible for ensuring that the recommendations of the IMR are acted upon.

74) Each agency was asked to;

- Critically appraise their agency's involvement with Adult A or Adult B and to identify any safeguarding or welfare concerns leading up to the homicide of Adult A;

- Consider whether concerns were acted upon appropriately, and if not, identify what professional or agency issues/barriers prevented this from happening;

- Consider the earlier history of Adult B to identify early warning signs and/or opportunities for early intervention (if applicable);

- Construct a comprehensive chronology of involvement by their agency over the period of time set out within the scope of the review.

75) The Independent Chair developed an IMR workshop for new authors requiring additional support to write an IMR report. The workshop was held on the 12th October 2012 and was attended by six agencies. The IMR authors received a presentation about the DHR process and the expectations of the IMR report. There was also an opportunity to ask questions and seek clarification.

76) The Review Panel initially requested Individual Management Reviews from;

- Devon and Cornwall Police
- Children and Young People's Service
- Cornwall and Isles of Scilly Primary Care Trust
- Cornwall Education (Schools, Achievement and Special Educational Needs)
- Cornwall Supported Housing
- Anti-Social Behaviour Team
- Adult Social Care
- Cornwall Foundation Trust – Mental Health Services
- Lifeline Services

77) Following examination of the Individual Management Reviews, the Review Panel asked for additional information (where relevant) from each agency to address the specific questions or requirements of the Terms of Reference.

78) Upon viewing each of the IMR's against the Terms of Reference and the amended scope of the review, the Independent Chair focussed on those that evidenced agency involvement between 2010 and 2012 unless there was a significant event that warranted inclusion.

79) The final Individual Management Reviews included for analysis within this report are;

a) Devon and Cornwall Police
b) Cornwall Foundation Trust – Mental Health Services
c) Cornwall and Isles of Scilly Primary Care Trust
d) Hartley Home Care (representing Adult Social Care)
e) Lifeline Services
f) Cornwall Supported Housing

80) The Author has included within section four of this report, a summary of agency involvement, an analysis of involvement and conclusions on whether the practice was in accordance with national and local requirements at that time.

81) In section five the Review Panel has drawn overall conclusions about what, if anything should have been done differently and, where appropriate, makes recommendations about what actions are required by each agency and by the Safer Cornwall Partnership to address the findings of the review. In addition, the Panel has made recommendations regarding any implications for national policy arising from the case.

Parallel Investigations

82) The Independent Chair contacted the HM Coroner for the County of Cornwall in writing on the 24th September 2012 advising Dr *(REDACTED)* of the commencement of the Domestic Homicide Review and inviting discussions on how to dovetail the Domestic Homicide Review and the Coroner's Inquest.

83) The Coroner did not hold an inquest into Adult A's death as the criminal investigation and subsequent trial sufficiently established who the deceased was and how, when and where the deceased came by his death.

84) Other than the Criminal Investigation, the Review Panel was not informed of any other parallel investigation or Serious Case Review (SCR).

Dissemination

85) It is anticipated at this stage that the final Overview Report and Executive Summary will be published. Internal Management Review reports will not be made publicly available. Whilst key issues will be shared with specific organisations the Overview Report will not be disseminated until clearance has been received from the Home Office Quality Assurance Group.

86) In order to secure agreement, pre-publication drafts of the overview report will be shared with the membership of the Review Panel, IMR authors and the Safer Cornwall Partnership Board.

87) The content of the Overview Report and Executive Summary will be suitably anonymised to protect the identity of the victim, perpetrator, relevant family members, staff and others to comply with the Data Protection Act 1998. The Overview Reports will be produced in a form suitable for publication with any redaction before publication. To assist and inform the redaction process the Safer Cornwall Partnership will once again refer to guidance developed by

Sheffield First in 2011.

88) Adult A and Adult B's family will be offered the opportunity to view the report prior to submission to the Home Office Quality Assurance Panel. After final changes, the family will receive a final copy of the report on the day prior to publication.

SECTION TWO

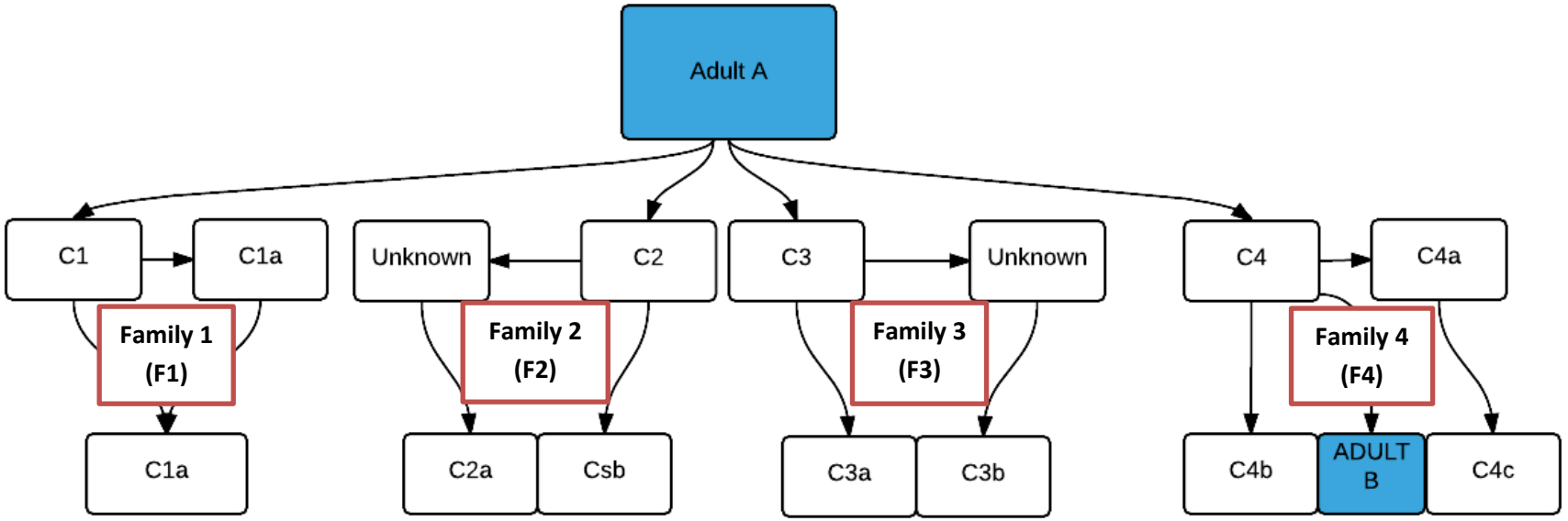
SECTION TWO: SYNOPSIS OF CASE

89) Table A: Key Relationships

Name	Year of Birth	Extended Family
Adult A (M)	1920	Victim – Head of Family, father of C1, C2, C3 and C4
Adult B (M)	1992	Perpetrator and Grandson of victim. Son of C4
First Son – C1 (M)	1947	**Family 1 - F1** Wife C1a Son C1b
Second Son – C2 (M)	1948	**Family 2 - F2** Daughter C2a Son C2b
Third Son – C3 (M)	1953	**Family 3 - F3** Daughter C3a Daughter C3b
Fourth Son – C4 (M) **Father of Adult B**	1960	**Family 4 - F4** Wife C4a Son (Adult B) Daughter C4b Step Son C4c

M = Male F= Female

90) Table C: Family Genogram



Circumstances

91) At 0218 hours on the 17th April 2012 Ambulance Services were called to a one bedroom, ground floor flat at *(REDACTED ADDRESS).* Paramedics arrived within 3 minutes to find Adult A conscious but lying face down on the living room floor. Nearby a coffee table had been upturned.

92) Adult A was accompanied by his eldest son C1 who had been alerted by Adult A's lifeline alarm at approximately 0130. Adult A told C1, Paramedics and Police that his grandson (Adult B) had entered the flat with a key, grabbed and twisted his neck before throwing him to the floor. He thought that Adult B was 'trying to break his neck'. He was complaining of neck pain and had not moved since the incident.

93) Before Adult A was taken to hospital, he asked C1 to fetch his wallet from under his pillow. The wallet was empty of its contents. Adult A stated that £300 was in the wallet before Adult B had entered the flat.

94) Adult A was conveyed to *REDACTED* Emergency Department. He developed complications on the 20th April 2012 and died at 1333 hours following a cardiac arrest.

The Deceased – Adult A

95) Adult A was born in 1920. He married in 1946 and had five sons. One son died in a car accident in 1977. Adult A served for 6 years in the British Army before entering the farming industry. In 1978 he became a caretaker in (REDACTED) and retired at 65. His wife died in 2005 and Adult A lived alone in sheltered accommodation with the support of his family and carers.

96) Adult A was described by C3 as *"the most generous man you could ever meet"* and *"a people's person, who loved life and enjoyed being involved with community life".* Adult A once lobbied the Council to have brambles removed from a community area and even encouraged them to landscape the space for public enjoyment. He enjoyed committees and grassroots football. C3 added that Adult A had an *"impact on everyone he met. He loved his carers and would*

frequently wind them up in a jovial way. He received meals on wheels each day but always had to add more gravy to his meals – he was very particular and liked things done his way…he was a fantastic man".

97) Adult A and Adult B's relationship was described by C3 and Adult A's carers as "good". It was generally known that Adult B and his sister C4b were Adult A's favourite grandchildren.

98) None of Adult A's family disclosed knowledge that Adult B was ever physically abusive towards him.

The Perpetrator – Adult B

99) Adult B was born in 1992 to C4 and C4a. He was described by both sides of the family as a *"Good lad, and a nice boy".* C4a said he was very caring boy who always did everything that was ever asked of him. He could cook a good meal and was always eager and willing to respond to Adult A's requests for assistance. He enjoyed visiting Adult A and spending time with him.

100) During Adult B's school years, he was elected by peers as 'Ball Captain' for two consecutive years, taking responsibility for organising sports events, teams and equipment. From Year 9 – 11 he enjoyed vocational work and undertook work experience in a garage. The employer provided a report to the school saying that Adult B was the type of student he would employ.

101) C4a stated that Adult B's character started to change when he reached 17 and started to experiment with Mephedrone. C4a thought that Adult B was *'very gullible and succumbed to peer pressure'*. He started to sleep for long periods of time (up to 48 hours) and became obsessive about the order of his room.

102) C4a added that it was not in Adult B's character to become a *"killer".* She was convinced that Mephedrone changed Adult B and that any person who took Mephedrone was at risk of acting completely out of character and even committing a murder.

Police Investigation

103) Devon and Cornwall Police were despatched to (REDACTED ADDRESS) immediately following an emergency call to Ambulance Services at 0218 hours on the 17th April 2012. The Police attended at 0223 and were met by C1 who let them in. When they entered the flat, they saw an elderly male (Adult A) prone on the floor with a small table and a bin overturned nearby. One of the Officers laid down beside Adult A so that he could speak to him.

104) Adult A said *"(Adult B) came in and was normal for quarter of an hour then he put his arms around my neck and started twisting it; he threw me on the ground here. I think he thought I was dead, I don't know how long he was here for".*

105) C1 was alerted by the Lifeline alarm and had attended the address immediately arriving at approximately 0215. Adult A said it took approximately 30 minutes to activate the alarm. Adult A thought that Adult B arrived at the property at approximately 0100hrs.

106) Before Adult A was conveyed to hospital, he asked C1 to fetch his wallet under his pillow. C1 did this in the presence of a Police Officer. The Officer opened the wallet and found it empty, to which Adult A replied *"He's had my money away then, if he'd just asked, I would have given him some".*

107) Adult A was taken to (REDACTED) Hospital complaining of severe pain in his neck and lower ribs. C1 followed in his car. The Officers remained at the property for a short time to take photographic evidence of the scene before exiting to try and locate Adult B.

108) Adult B was arrested at 1025 hours on the 17th April 2012 as he exited a taxi outside of his parent's house. He was arrested for the assault on his grandfather and for the theft of money from the property. Adult B was conveyed to custody where his clothing and personal belongings (contained on his person) were seized.

109) Adult B was interviewed without a solicitor on two occasions on the 17th April 2012. He changed his account of his whereabouts during the second interview

and admitted to going to his grandfather's house, attacking him and stealing the money.

110) Adult B was remanded at HMP *(REDACTED)*. He was produced from HMP (*REDACTED)* on the 11th June 2012 and was arrested on suspicion of murder. He was taken to (*REDACTED)* Police Station where he was further interviewed in the presence of a solicitor. Adult B made 'no comment' to all questions put to him.

111) The evidence was placed before the Crown Prosecution Service (CPS) following the interview. The CPS made the decision to charge Adult B with the murder of Adult A and he was charged at 1408 hours on the same day (11th June 2012).

112) In addition to Adult B's account, Devon and Cornwall Police also sought witness statements from (not an exhaustive list);

Table D: 112a

Code	Relationship to…
C1	Eldest Son of Adult A
C3	Third Son of Adult A, Uncle to Adult B
C4a	Mother of Adult B, Daughter-in Law of Adult A
S4	Girlfriend of Adult B
C2b	Cousin of Adult B, Son of C2, Grandson of Adult A
S5	Friend of C2b, Boyfriend of C3a
S20	Barman at the *REDACTED* Arms, Friend of S5
S18	Friend of S19 and S20
S19	Friend of S18 and S20
S14	Self Employed Taxi Driver 1
S11	Taxi Operator
S13	Taxi Driver 2

S50	Former Employer of Adult B
S28	Carer 1 to Adult A
S52	Carer 2 to Adult A

Post Mortem

113) The Post mortem was conducted by Home Office Pathologist Dr *(REDACTED)* on the 23rd April 2012 at *(REDACTED)* Hospital Mortuary.

Coroner's Inquest

114) Paragraph 15.1 of the Ministry of Justice Guide to Coroners and Inquests and Charter for Coroner Services (March 2012) states;

> *Where a person has been sent for trial for causing, allowing or assisting a death, for example by murder or manslaughter, any inquest is in most cases adjourned until the criminal trial is over. On adjourning an inquest, the coroner must send the Registrar of Births and Deaths a certificate stating the particulars that are needed to register the death and for a death certificate to be issued. When the trial is over, the coroner will decide whether to resume the inquest. There may be no need, for example, if all the facts surrounding the death have emerged at the trial. If the inquest is resumed, however, the finding of the inquest as to the cause of death cannot be inconsistent with the outcome of the criminal trial.*

115) The Coroner did not resume an Inquest into the death of Adult A after the trial as the criminal justice process sufficiently established who the deceased was and how, when and where the deceased came by his death. This was not disputed by the pathologists or the defence and prosecution teams.

Court Dates and Outcome

116) The trial at (REDACTED) Crown Court commenced on the 24th of June 2013 and concluded on the 1st of July 2013, lasting six days. The Independent Chair and Domestic Abuse & Sexual Violence Strategy Manager for Cornwall and the

Isles of Scilly attended (REDACTED) Crown Court on 27th June to hear the Defence and Prosecution closing statements.

117) On the 28th June 2013 Adult B was found guilty by the unanimous verdict of a jury, of the murder and robbery of Adult A. The Honourable Mr Justice (REDACTED), sentencing Adult B (on the 1st July 2013) said he would serve a minimum of 15 years for killing his grandfather. He added:

> *"You lost your temper and in a drunken, drug-fuelled rage you attacked him. He was a frail old man - you are a well-built man.*
>
> *"Your grandfather was particularly vulnerable due to his ill health and disability. You knew well what had happened and you intended what you did.*
>
> *"You left him lying, helpless on the floor and you didn't call for help. You have deprived him of his life and your family of its head."*[1]

118) Adult B will be eligible for parole from 2028.

Equality and Diversity Statement

119) This diversity statement was written following consideration of The Equality Act 2010 which came into force on 1 October 2010 to legally protect people from discrimination in the workplace and in wider society. The Equality Act 2010 replaces all existing equality laws with one single act, making the law easier to understand for individuals and strengthening protection in some situations.

120) Adult A (the deceased) was a white British National. He was 91 years old at the time of the homicide. Adult A had multiple long term health conditions resulting from hypertension, coronary artery disease, kidney disease, bronchitis, atrial fibulation and a previous diagnosis of bowel cancer.

121) Adult A was eligible for support from Adult Care and Support and required assistance with personal care and maintaining food and fluid intake. Carers attended 4 times a day and family members helped with grocery shopping, cleaning, errands, finances and laundry. Adult A was able to mobilise short

[1] http://www.cornishguardian.co.uk/JAILED-Stephen-Lang-serve-15-years-murder/story-19444327-detail/story.html

distances with the use of a wheeled trolley and used a wheel chair for longer distances. He was described as mentally 'alert' with good communication skills.

122) Due to Adult A's age, illnesses and receipt of community care services, he would have been considered a vulnerable adult under the broad definition of a 'vulnerable adult' referred to in the 1997 Consultation Paper *'Who Decides?'*[2], issued by the Lord Chancellor's Department;

- *"A vulnerable adult is a person aged 18 or over who is or may be in need of community care services by reason of mental or other disability, age or illness; and who is or may be unable to take care of him or herself, or unable to protect him or herself against significant harm or exploitation".*[3]

123) Adult B (the perpetrator) is 21 (at the date of this report) and is also a white British National. Adult B does not have a physical disability.

124) Adult B is not married and does not have any biological children.

125) Neither Adult A nor Adult B had/have ever undergone any gender reassignment.

126) Adult A and Adult B's religious and philosophical beliefs are not known. It is not clear from the review that Adult A or Adult B had any religious or philosophical beliefs that had an impact on their life choices or the way in which they lived their lives.

127) There is no evidence that Adult A or Adult B were *directly* discriminated against by any agency based on the nine protected characteristics of people who use services under the Equality Act 2010 *e.g. Disability, Sex (gender), Gender reassignment, Pregnancy and maternity, Race, Religion or belief, Sexual orientation, Age, Marriage or Civil partnership.*

128) The Review Panel has considered whether the *gender* and relationship of Adult A and Adult B would have created a barrier to services, in that family abuse, especially non-intimate male on male abuse, has the potential to be

[2] See also Making decisions – a report issued in the light of responses to the consultation on the Law Commission's document (1999).
[3] Department of Health No secrets: Guidance on developing and implementing multi-agency policies and procedures to protect vulnerable adults from abuse (2000)

overlooked in the 'traditional' sense of domestic abuse e.g. Females are statistically more likely to be victims of domestic abuse.[4]

NARRATIVE CHRONOLOGY OF AGENCY INVOLVEMENT

129) A full chronology of agency contact can be found at Appendix A.

Summary of agency involvement (Reverse Chronological Order)

2010

130) At 1650 hours on the 28th February 2010 Adult B was reported missing by his Mother (C4a). He was last seen on the eve of the 27th February 2010 near a nightclub in (REDACTED). His friends returned to (REDACTED) without him at 23:30 hours. Devon and Cornwall Police completed a Community Policing and Case Tracking System (COMPACT) Report and risk assessed the case as 'medium'.

131) Adult B's family told Devon and Cornwall Police that they had recently found out that Adult B was experimenting with "Bounce", formally known as Mephedrone.

132) It was believed that Adult B had checked in to a hotel in the (REDACTED) Area. His parents commuted to (REDACTED) and searched each of the hotels in person. A short time later a Manager from a local hotel in (REDACTED) made contact with the Police to inform them that Adult B had checked in at 0115 hours. The Hotel Manager commented that Adult B *"had a lot of cash lying around his room".*

133) Adult B's father (C4) was contacted by Police. He collected Adult B from the hotel and chauffeured him home.

[4] Office for National Statistics (ONS), 2013.

134) Two days later, on the 2nd March 2010, Adult B was brought to (REDACTED) Medical Centre by his Mother (C4a). His Mother expressed concerns that Adult B was exhibiting paranoid ideas, hallucinations, insomnia and aggressive behaviour. He was also hiding knives and misusing substances ("Bounce"). She told the GP that they (C4a and C4) had recently had to collect him from a hotel in (REDACTED) after he had become paranoid that three people were watching him.

135) Adult B's G.P made a verbal referral to the North Cornwall Mental Health Team for an assessment for first presentation psychosis. A face to face assessment was undertaken on the 3rd March 2010 by a student nurse and a Community Psychiatric Nurse from the North Cornwall Mental Health Team. Details of social circumstances and family dynamics were enquired about as part of the Mental Health Assessment and information was recorded. This was the first professional reference to Adult B's relationship with Adult A.

136) A written letter was sent to Adult B's GP from the North Cornwall Mental Health Team with the outcome of the assessment, that there was no mental ill health present at time of the assessment. Due to his age (17) a referral was made to the Early Intervention Service as a precautionary measure to ensure that there was not an emerging mental illness.

137) The Early Intervention Service sent a letter to Adult B inviting him to attend an appointment on the 12th March 2010 at (REDACTED). Adult B did not attend the appointment. A further letter was sent offering another appointment for the 17th March 2010 at (REDACTED) but Adult B failed to attend the second scheduled appointment.

138) Two days later on the 19th March, Devon and Cornwall Police received intelligence that a male (known to Adult B) had knocked on the door of the family home and demanded £100 for the repayment of a 'loan' that Adult B had borrowed. C4 closed the door on the man but advised Adult B to pay.

139) The next intelligence report was received on the 20th March and it described Adult B as experiencing psychotic episodes since experimenting with “Bounce” since December 2009. It was believed that Adult B had obtained the drugs from the same man that attended the family home on the 19th March 2010.

140) The final intelligence report was dated the 21st March 2010 and stated that Adult B had paid the man £100 for buying Mephedrone and that they were now on speaking terms.

141) Between the 25th March 2010 and the 1st of June 2010, The CPN from the Early Intervention Service tried on four separate occasions to contact Adult B to reschedule another appointment. On the 12th May, the CPN was able to speak to C4a who said that Adult B was now back to his normal self and had stopped taking “Bounce”.

142) A Multi-Disciplinary Team Meeting was held during the week of 1st June 2010. The decision was made to send a letter advising of Adult B’s discharge from the Early Intervention Team.

2011

143) There appears to be no recorded agency contact with Adult B from the date of discharge from the Early Intervention Team until the 27th July the following year (2011) when Adult B was arrested, with his cousin (C2b) for an assault on a 15 year old boy. The boy had made derogatory comments towards both Adult B and C2b which triggered the aggressive response. Adult B and C2b pleaded guilty to assault and received a conditional discharge.

144) During August of the same year (22.08.2011) a referral was sent to the Rapid Assessment Team at Adult Care and Support for Adult A. The referrer (Adult A’s GP) expressed concerns regarding frailty, falls, risk, poor diet and fluid intake, and poor management of medication. A home visit by the Rapid Assessment Team was carried out and Adult A was admitted the same day to a temporary

placement in a residential home.

145) Adult A was discharged home on the 28th August 2011 with a care agency plan and family support. A full assessment was undertaken on the 7th September 2011 at Adult A's sheltered accommodation. The outcome of the assessment was that Adult A could continue to live at home with assistance from Adult Care and Support. A care plan was developed which included four care visits a day to help with personal hygiene, food and fluid intake. In addition to the daily carers, the Supported Housing Officer would attend three times a week, the District Nurses would visit three times each month and Lifeline was installed.

146) Other than the approved agency contact with Adult A as part of his care plan for independent living and general medical complaints, there was no further Professional contact with Adult A or B until 2012.

2012

147) At 0419 hours on the 11th April 2012, C4 telephoned Devon and Cornwall Constabulary to report that his car had been stolen in the last 10 minutes. At approximately 0450 hours Police located the vehicle heading towards (REDACTED) and being driven by Adult B.

148) Adult B was in the company of three other males. He was arrested and provided a positive roadside breath test. His parents confirmed that Adult B had not been given permission to drive the car as he only held a provisional licence.

149) Adult B was convicted on the 17th of May 2012 of aggravated vehicle taking, driving with excess alcohol, driving otherwise than in accordance with a licence and breach of a conditional discharge.

150) Between the dates of taking his parents' car without consent and his conviction for aggravated vehicle taking, Adult B was arrested for the assault and robbery of Adult A.

The Events of 16th and 17th April 2012

Adult A

151) During the early hours of the 17th of April 2012, Adult A was at home, sitting in his living room as normal. He liked to stay up late watching TV until approximately 0100 – 0200 hours. Although his carers visited at approximately 2100 hours each evening to assist Adult B with getting ready for bed, he did not like to go to bed until the early hours.

Adult B

152) Adult B was socialising with his cousin C2b on the evening of the 16th April 2012. They visited the (REDACTED) Arms together at approximately 21:47 hours. At this time Adult B was wearing a grey short sleeve polo top and jeans. CCTV footage shows Adult B purchasing and drinking three pints and one bottle of alcohol.

153) At 22:46 Adult B, C2b and S5 (a friend of C2b and boyfriend of C3a) left the (REDACTED) Arms and walked to another public house, the (REDACTED) Arms. They stayed for approximately 20 minutes before walking to a third public house, the (REDACTED) Inn. Here Adult B was seen (by CCTV) to purchase and drink a further pint of alcohol.

154) At 23:21 all three men left the (REDACTED) Inn and returned to the (REDACTED) Arms. Adult B purchased and drank a pint of alcohol.

17th April 2012

155) At four minutes past midnight in the early hours of the 17th of April 2012, Adult B and C2b left the (REDACTED) Arms and walked to a local 24-hour Tesco Store where they purchased a crate of beer.

156) At 0022 hours, Adult B and C2b walked to another cousins' house (C3a) where S5 and three other people were present. S5 was the boyfriend of C3a and shared a flat with her but C3a was on holiday at the time. Adult B and C2b were

described as being “very intoxicated” when they arrived.

157) Witnesses at the flat state that after approximately half an hour, Adult B said that he was going home to retrieve more money.

158) Adult B arrived at his Grandfather’s sheltered accommodation at approximately 0100 hours. He let himself into the flat using a key which was attached to a set of allotment keys belonging to his parents (C4 and C4a). Adult A was sitting in his arm chair watching TV when Adult B entered. Adult A said *“He (Adult B) was stood beside me, arms around my neck. He then had me on the floor. I lay on the floor for a while afraid to move. He lost everything, his temper and his senses…”* After Adult B left, it took Adult A approximately 30 minutes to activate his Lifeline Alarm.

159) Just after 0100 Adult B called for a taxi to collect him from the Texaco Garage, (REDACTED) and take him approximately 25 miles to (REDACTED). Adult B offered the taxi driver £500. The driver said the sum was exorbitant but Adult B said *“My mate has just won £5000”.* The taxi collected Adult B but as the driver stopped at Tesco to put fuel in the car, Adult B said that he wanted to *“get his mate”* and left the taxi, promising to meet at an agreed location as soon as possible. Adult B never returned.

160) Adult B arrived at S5’s and C3a’s flat at approximately 0200 hours and was soaking wet from a downpour of rain. His clothing was saturated so S5 lent Adult B an orange coloured t-shirt. Two witnesses said that Adult B was rather quiet on his return, *“less cocky”* and *“not himself”.* S5 recalled seeing Adult B reach for a phone in his pocket and remove a large amount of money, which he found surprising.

161) Sometime between 0530 and 0550 hours Adult B left the flat and walked to the (REDACTED) leading to (REDACTED) where he said he hitched a lift with an unknown male into (REDACTED).

162) At 0920 hours a taxi operator received a call from Adult B at a hotel in REDACTED (the same hotel as mentioned in 2010). He requested collection from a nearby brasserie, to be taken back to (REDACTED). The taxi driver recalled Adult B wearing an orange t-shirt and being tired, anxious and angry**.**

163) At 0930 hours, Adult A was assessed by Dr G and Registrar Mr (REDACTED) working in neurosurgery at (REDACTED) Hospital. Of the seven vertebrae in the neck part of the spine, the CT scan revealed that Adult A had fractures to C2 C3 C5 C6 and C7. The C7 vertebra was broken on both sides.

164) Adult B arrived at his parent's house at approximately 1020 hours on the 17th April 2012, where he was arrested by Officers outside the property for the assault and robbery of his grandfather, Adult A.

165) Three days after the assault on the 20th of April 2012, Adult A developed complications with breathing. On return from a CT scan, the Doctor noticed that Adult A was cyanosed and not breathing. CPR was commenced by the Doctors present. Within 1-2 minutes they were joined by the Crash Team who took over. After 30 minutes of CPR, Adult A seemed to stabilise but then went into arrest. Adult A was pronounced dead at 1133 hours on the 20th April 2012.

SECTION THREE

SECTION THREE: ANALYSIS OF FAMILY CONTRIBUTION

166) In addition to an analysis of the response of *services* involved with Adult A and Adult B (see Section Four), the Review Panel wished to include the views and opinions of family members to establish whether *they were aware of any previous abusive behaviour from the perpetrator to the victim* as per the Terms of Reference.

167) The Independent Chair and Domestic and Sexual Violence Strategic Manager for Cornwall and the Isles of Scilly met with family members from F3 and F4 (see key relationships 89) above). Family 3 (F3) consisted of C3 and his wife who contributed on behalf of the deceased (Adult A). Family 4 (F4) included C4, C4a and C4b who contributed to the review in support of Adult A and B. When referring to family groups rather than individuals, the Author will use F3 and F4.

168) Permission was granted to include their expressed views in this section of the Overview Report. The Independent Chair has also included the testimony of family members obtained as part of the criminal investigation.

F3 - Family Contribution C3

169) C3 is the third son of Adult A. He is married and lives in (REDACTED). He is the father of C3a and C3b.

170) The Independent Chair and Domestic and Sexual Violence Strategic Manager for Cornwall and the Isles of Scilly met with C3 and his wife on the 27th August 2013 at the family home.

171) C3 had already received the Terms of Reference for the Domestic Homicide Review and Home Office Leaflet for Friends and Family. He did not wish to add any amendments to the Terms of Reference and confirmed that he understood the purpose of our visit.

172) Firstly C3 wished to express his frustration and disappointment at the amount of time it took the Defence Team to decide on a second post mortem. This delay meant that Adult A's body could not be released to the family for burial for five months. The trial date was also deferred from November 2012 until 24th June 2013, resulting in a further seven months whereby the family were held in *'limbo'.*

173) The Chair was told that this had a detrimental effect on C3's health which led to heart problems requiring further medical investigation. C3 had also experienced anxiety attacks and depression since the homicide. C3 believed the criminal justice process added to the stress of the situation and was particularly upset that Adult B's Defence was allowed to withhold the burial of his father. He was frustrated that the rights of the defendant superseded the needs and welfare of the family.

174) C3 referred to Adult A as *"Father"* and described him as *"the most generous man you could ever meet…. He had an impact on everyone he met. Even his 4 year old great-grandchild said recently 'I miss 'Gogs'".* C3 added *"He was a people's person who loved life…he was a legend, a truly fantastic man".*

175) Recalling the events of the 16th - 20th April 2012, C3 described how he was on holiday when the incident occurred. He was the primary name on the Lifeline list of contacts and was on holiday when the emergency call came through, hence why C1 was called to the property instead. C3 did not speak to his father again until he was in hospital. He added *"I had no time to prepare for what happened. I was not prepared… I feel as if I have been robbed".*

176) Asked about Adult A's relationship with Adult B, C3 replied *"He (Adult B) was a nice boy, I have to say it; he was a nice boy".* He added that Adult B would visit his grandfather a couple of times a week and would often help with sorting the laundry, taking out the bins and general errands. C3 was aware that Adult A would pay his grandchildren £5.00 for helping him out. He did not feel that Adult B would ever have asked for payment because it was something that Adult A liked to do.

177) On the 14th of April 2012, C3 spoke to Adult A on the telephone. He told C3 that Adult B had stopped by to help sort out the washing and had added *"He's a good lad"* when referring to him.

178) C3 thought that Adult A and Adult B *"had a very good relationship".* He acknowledged that Adult B and his sister C4a were generally Adult A's favourite grandchildren.

179) C3 was aware that in the weeks preceding the homicide, Adult B's father (C4) had *"Bailed him (Adult B) out".* He thought that C4 had asked for money from Adult A in order to clear drug debts created by Adult B. C3 recalled being at Adult A's sheltered accommodation with C4 two weeks before the incident and experiencing an *"atmosphere in the flat".* Later Adult A told C3 that *"(Adult B) was in trouble again".*

180) Before the homicide, the two families lived in the same street. C3 said he was aware that Adult B had been experimenting with alcohol and drugs as he was able to hear incidents in the street late at night. He believed Adult B to have *"a temper on drink".*

181) C3 had heard from other family members that Adult B had a £140 a day drug habit. He thought there had been a prolonged period of drug taking but was sure that his parents were trying to help him stop. He felt that the more C4 helped Adult B, the less likely he was to stop.

182) C3 felt that Adult B *"was at his worse"* on the night he took his parents car without permission (11th April 2012). C3 struggled to comprehend why Adult B was not remanded in custody after being arrested for aggravated vehicle taking, driving with excess alcohol, driving otherwise than in accordance with a licence and breach of a conditional discharge. He believed that breaching a conditional discharge should have been sufficient to remand him in custody. C3 felt that the incident on the 17th April 2012 could have been avoided if Adult B had of been remanded in custody.

183) C3 thought the attack on Adult A in the early hours of the 17th April 2012 *"was premeditated".* He said *"I think he planned it. (Adult B) knew that Father would be up at 0100 hours. He told Father that he had just finished work – but he*

wasn't working. Father wouldn't have been worried at that point but he might have been suspicious". He added *"I think (Adult B) left Father for dead. Father told me he played dead so that Adult B wouldn't come back".*

184) C3 thought the motive for attacking Adult A was *"fuelled by drugs"* but added *"We wanted the murder verdict. We would have wanted the same outcome even if it was a stranger".*

185) Asked if there was anything else that they would like to contribute to the review, C3 and his wife wanted to know why CCTV was not installed at the sheltered accommodation where Adult A lived. C3 commented *"If Father had been killed that night, he wouldn't have been able to tell us that (Adult B) had done it. There would be no footage of who had entered the flat".*

186) The Independent Chair asked if they had received appropriate support during and after the criminal investigation, trial and sentencing. The Chair was told that the family had been allocated a Victim Support Homicide Caseworker *"who was fantastic".* However C3's wife informed the Independent Chair that she made contact with Victim Support herself to facilitate support following the *"breakdown"* of C3. She added *"The Police could have arranged support quicker".* C3 and his wife were also uncomfortable with same Family Liaison Officer (FLO) being allocated to each side of the family divide. On occasions, they believed that information was exchanged by the FLO that resulted in heightened emotions.

F4 - Family Contribution C4, C4a and C4b

187) The Independent Chair and Domestic and Sexual Violence Strategic Manager for Cornwall and the Isles of Scilly met with Adult B's Father (C4), Mother (C4a) and Sister (C4b) on Sunday 25th August 2013 at the family home.

188) The sensitive dynamics of the family were discussed and it was acknowledged that C4 was in a very difficult position with the victim being his father and the perpetrator being his son. C4 expressed his despair at the *"impossible situation whereby he mourned the loss of his father and yet felt obliged to stand by his Son".*

189) The family felt that the Criminal Justice System was not accommodating of such a complex and sensitive family dynamic. Whilst C3 and other family members had received support, and even a private room at the court, C4 had not been offered any practical or emotional support. It was felt that both C4 and C4b needed some therapeutic support to help them to cope with the solemnity of the situation; however, they believed that they were not deemed worthy of support because the perpetrator was their son/brother. C4 said *"We have done nothing wrong – but we have been made to feel like we have".*

190) C4 and C4a were asked about the relationship between Adult A and Adult B. They stated that *"although Adult A could be very demanding on the family"* the relationship *"was very close*". They added that *"(Adult B) was very caring and would do anything asked of him….he would visit (Adult A) most days and help out with little jobs…whereas some of the other grandchildren would only visit on holidays and Christmas, Adult B and C4b would visit every day between them. It wasn't any bother; they had a good relationship with him".*

191) Adult B's family described the shock and horror of finding out that Adult B had attacked Adult A. C4a said *"The drugs must have caused a chemical imbalance…he was never the same after he experienced a psychotic episode in 2010. This was completely out of character; I mean this is not in his character. He is not a killer".*

192) C4a explained how she had taken her son to the G.P in March 2010 for help after they rescued him from a hotel in (REDACTED) two days earlier. C4a said that Adult B had started to experiment with *'Bounce'* at 17 years old. She added *"He started to change at 17; he would sleep for long periods of time, sometimes 48 hours, he was OCD about his room; he was paranoid, withdrawn; not himself…we even had suppliers phoning (C4) asking if (Adult B) still wanted the 'Bounce' – he slammed the phone down obviously… (C4b) found drugs; which she thought was 'Bounce' in his bedroom and also found (Adult B) talking to a paper bag. We knew he was not right, that is why I took him to see our G.P"*

193) Asked about the quality and effectiveness of the response from the G.P, C4a said that it was very difficult to get Adult B to the Doctor's. She explained how she had to *'hoodwink Adult B and literally drive him to the Surgery and walk him*

into the appointment'. Although the G.P referred Adult B for a mental health assessment, C4a was surprised that there was no information, literature or education offered in relation to the specific drugs Adult B had been experimenting with from the surgery.

194) C4a thought that there was a *"downgrading of concern"* because the drug Adult B had been taking was not categorised as a Class A drug like Heroin or Cocaine. Mephedrone did not become an illegal Class B drug until 16th April 2010; some 45 days after Adult B's first visit to the G.Ps. Therefore at the time of his visit, Mephedrone was still a 'legal high'.

195) C4a believes that the G.P was '*blasé'* about the effects of Mephedrone and the impact it can have on people who used it. C4a said that the drug had become a serious problem in the area with many young people experimenting with 'Bounce' without understanding the risks.

196) C4a recalled taking Adult B to a property in (REDACTED) for support around his use of Mephedrone. She remembered taking Adult B to the service but could not remember the name of the agency or the specific address. C4a said that the support Adult B received at the service was *"disappointing, weak and too soft"* adding, *"The tip-toe approach didn't work….they asked softly 'why do you think you take it?' – That wasn't what he needed; he needed a serious wake-up call; he needed a professional to tell him about the dangers of the drug and what it was doing to him…he needed to hear the harsh truth".*

197) When asked to rate the support Adult B was offered after her visit to the G.P, C4a said *"Zero, because there was no support. Nobody helped us. We weren't given any literature on the specific drug; nothing. I had to do my own research to find out more about it. If I knew what it was capable of, I wouldn't have let him out. I would have tried to keep him in".*

198) Adult B's family were very concerned that youth in the area were still using Mephedrone and had not learnt from Adult B's situation. They thought it was vital for *'hard hitting'* drug education to be delivered in local schools so that young people were more informed about the risks of Mephedrone. C4 and C4a each

added that they would be prepared to talk to students if they thought it would help other families.

Panel Analysis of Family Contribution

199) The Panel would like to thank both families for participating in the Review and sharing their personal memories, thoughts and feelings in order that we can learn from their experiences. The Panel is aware that the homicide of Adult A has divided the family and as such, acknowledges that this may be the first time that they have read about the physical and emotional impact on each other. The Panel would like to reiterate the offer of professional/emotional support and will facilitate this for any family member who requires or desires it.

200) The following section will aim to address the concerns and/or opinions of the family members and conclude on whether *they were aware of any previous abusive behaviour from the perpetrator to the victim* as per the Terms of Reference.

Trauma of the Criminal Justice Process

201) C3's frustration with the criminal justice system echoes the key concerns identified by the Victims Commissioner, Louise Casey CB in 2011 following a Review into the Needs of Families Bereaved by Homicide. The review states;

> *A unique feature of being bereaved by homicide is that at a time of terrible tragedy, of trauma and of deep emotion, as families take in the loss of someone close to them, the criminal justice system starts to move into action.*
>
> *And although bereaved families in no way want to stand in the way of bringing a perpetrator to justice, and will most often have an overwhelmingly strong desire for this to occur – the way that the system operates can leave families trembling in its wake. Bereaved families lose all control over their loved one as the Crown appropriates the body and determines when it can be returned for burial….In the next weeks, months and years, their loved one's death and who was responsible for it, may become the focus of their life. Yet the bereaved family doesn't determine or control any of this – the investigation, trial, verdict and sentence, appeal, parole process all happen*

around them, with the family entitled to some information and some explanation but little voice, little influence and little power.[5]

202) As with 79% of families that were consulted for the Review into the Needs of Families Bereaved by Homicide (2011), C3 experienced a significant delay with the release of the body for burial. For C3 and many other bereaved families, the idea that the perpetrator can still control the victim in death through delaying their burial is deeply distressing.

203) Following a homicide, the Coroner takes control of the body, ordering a post mortem to establish the cause of death. Because the body is evidence, a suspect can request their own post mortem. If granted this means that the victim is subject to further examinations. Additional post mortems cause a delay in burial. In this case, that delay was circa of 5 months, which appears to be beyond the good practice guidelines of The Ministry of Justice Guide to Coroners and Inquests and Charter for Coroner Services (March 2012), which states;

Where there is a criminal investigation into the death, there may be a further post-mortem examination. The coroner will make every effort for this decision to be taken as soon as possible, and the body will be released for burial or cremation at the earliest opportunity. If, however, no charges have been made in connection with the death within 28 days of the discovery of the body, the coroner will arrange a second post-mortem examination by a pathologist independent of the first, to be used by any future defence. The body will then be released at the earliest opportunity[6]*.*

204) The absence of a definitive cut-off time for the release of a body has been a contentious issue for a number of years. Although The Ministry of Justice Guide to Coroners and Inquests and Charter for Coroner Services (March 2012) aims to address the imbalance between the rights of the perpetrator and the needs of the bereaved family, the Charter is voluntary and Coroners are not obligated to meet the benchmark standards. There does not appear to be any Government audit of the effectiveness of the Charter or any redress for Coroners who do not meet national standards.

[5] Review into the Needs of Families Bereaved by Homicide - Louise Casey CB - July 2011 p. 31
[6] The Ministry of Justice Guide to Coroners and Inquests and Charter for Coroner Services (March 2012)

205) The family reluctantly endured the unacceptable delay for the release of Adult A's body for burial because they did not know how to challenge the Defence Team or Coroner's decision. Had they received the early support of victim-led representative (such as a Victim Support Homicide Case Worker) C3 might have been empowered to challenge the decisions and reduce the level of anxiety and stress, caused by waiting.

Health Implications

206) The Independent Chair was told that the criminal justice process had a negative impact on C3's health, including heart problems, depression and anxiety. The general health toll of bereavement (by homicide) was revealed in the largest survey of bereaved families ever undertaken (417 families) in 2011 as part of the Review into the Needs of Families Bereaved by Homicide; which discovered:

- 80% had suffered trauma-related symptoms;
- Three-quarters suffered depression;
- 100% said that their health was affected in some way, and eight-out-of-ten (83%) said their physical health was affected[7];

207) Although the survey was not a clinical assessment nor did its findings assess the severity, persistence or duration of symptoms, given the very high proportion of families experiencing ill health, and the high risk of traumatic grief developing into Post Traumatic Stress Disorder (PTSD)[8], it would seem vital that families are able to have an assessment to identify if they require trauma-related therapy, or bereavement counselling or other intervention[9].

208) Unfortunately C3 was not assessed or offered pre or post trial therapy following the homicide of his father. Equally, C4 and C4b were not offered therapy despite being directly related to, and distressed by the homicide of Adult A.

[7] Review into the Needs of Families Bereaved by Homicide - Louise Casey CB July 2011 pg. 6
[8] Amick-McMullan, A., Kilpatrick, D, Veronen, L., Smith, S. (1988) 'Family Survivors of Homicide Victims: Theoretical Perspectives and an Exploratory Study' in *Journal of Traumatic Stress*, Vol.2, No.1.
[9] Review into the Needs of Families Bereaved by Homicide - Louise Casey CB July 2011 pg. 15

209) Since the homicide of Adult A, a new Code of Practice for Victims of Crime was introduced by The Ministry of Justice in October 2013. The Code sets out minimum standards of services to be provided to victims of criminal conduct by criminal justice organisations in England and Wales. This includes facilitating pre-trial therapy for any child/young person, or adult that fall into the three priority areas;

- Victims of the most serious crime;
- persistently targeted victims; and
- vulnerable or intimidated victims.

210) The Code states that;

'Police or any other service provider acting as the main point of contact in the case, should inform those victims identified in the three priority categories that pre-trial therapy is available if needed, and, if requested, will be facilitated. The relevant service provider must also refer victims in the three priority categories to specialist organisations where appropriate and available'[10].

211) Although the DHR Panel welcomes the New Code of Practice for Victims of Crime, the minimum standard for facilitating pre-trial therapy remains rather *'woolly'* in that the Police (or other service providers) are obliged to refer a victim for therapy (if required or requested) but have no jurisdiction over whether those services (especially those provided by specialist voluntary organisations) accept the referral or offer treatment.

212) Despite the New Code of Practice for Victims of Crime being introduced after the homicide of Adult A, both sides of the family stated that they experienced symptoms of trauma related illness during the criminal justice process. Applying the benefit of hindsight, it could be considered a missed opportunity by the Police and Family Liaison Officers to enquire about the health and wellbeing of family members and, as a matter of good professional practice, facilitate a referral for therapeutic support.

[10] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/254459/code-of-practice-victims-of-crime.pdf

213) The Independent Chair was informed that C4a (Adult B's Mother) declined Police Family Liaison Officer as she was uncomfortable with the notion of a Detective in the family home. This meant that the family of Adult B had very limited contact with Police or other statutory agencies. Whilst the complex and sensitive family dynamics in this case presented Police Officers with a challenge, the age of C4b (being only 16 at the time of the homicide) should have been considered and support offered, regardless of her relation to the accused.

214) Following the meetings between the Independent Chair, the Domestic and Sexual Violence Strategic Manager and the families (F3 and F4) a letter was sent advising them of free counselling services available in their local area. Family members were advised that they could access Outlook Southwest via their GP, Cruse Bereavement Counselling and a Cruse Support Group within the (REDACTED) area.

Police Procedures

215) C3 and his family have reflected upon and analysed the events leading up to the 17th April 2012 and subsequent criminal justice process in microscopic detail to try and make sense of what has happened. This is evident in C3's struggle to comprehend why Adult B was not remanded in custody after being arrested for aggravated vehicle taking, driving with excess alcohol, driving otherwise than in accordance with a licence and breach of a conditional discharge.

216) C3 believes that the decision to remand Adult B on bail provided him with the opportunity to assault Adult A just 6 days later. The Panel is keen to address this viewpoint through this DHR to help the family understand the police/prosecution decision-making process following the arrest of an individual;

217) The Bail Act of 1976 intends that unless one or more of the reasons outlined below can be **demonstrated** by the prosecution, then the individual in question should be **remanded on bail**, meaning they are free to leave custody but must attend court on the next occasion. This is called the 'presumption in favour of bail'.

Reasons that must be *demonstrated* by the Prosecution to remand an individual **in prison** are;

- The individual has previous convictions for similar offences;
- There is reason to believe that the individual could leave the court's jurisdiction to avoid its trial and possible punishment;
- There is reason to believe that the individual may destroy evidence and interfere with witnesses;
- There are reasonable grounds to believe an individual would commit further offences before their trial;
- The suspect is believed to be in danger from accomplices, victims, or vigilantes[11].

218) At the time of Adult B's arrest for aggravated vehicle taking, driving with excess alcohol, driving otherwise than in accordance with a licence and breach of a conditional discharge, he did not have any previous convictions for similar offences. As Adult B had previously pleaded guilty to common assault and accepted the conditional discharge, there were no reasonable grounds to believe that Adult B would leave the area to avoid trial or punishment.

219) As Adult B was caught driving his parents car and had failed the roadside breath test in the presence of a Police Officer, there was no reason to believe that Adult B would (or could) destroy evidence or interfere with witnesses.

220) Adult B did not disclose any information that would have led the Police to believe that he was in danger from accomplices or vigilantes. Although the Police had intelligence to suggest that Adult B had been associated with illegal drugs in the past, he denied having any problems or concerns with drugs or alcohol when detained and assessed at the Police Station on the 11th April 2012.

221) It is difficult knowing the events that followed just 6 days after Adult B was remand on bail, to review whether Police Officers had reasonable grounds to believe he would commit further offences before the trial. With the benefit of

[11] http://www.offendersfamilieshelpline.org/index.php/remand-into-custody/

hindsight, Adult B's arrest on the 11th April 2012 could be seen as a decline in his behaviour, and a significant warning of what was to come; however the Police must make decisions based on the information available to them at the time. There was no possible way of knowing what Adult B would go on to do just 6 days later. As Adult B had a relatively minor criminal history – last contact being 8 months prior to taking his parents' car - the Police Officer's had no reasonable grounds to remand Adult B in prison for fear that he would commit another offence before the trial.

222) Based on the criteria stipulated by the Bail Act of 1976, the Police would not have been able to demonstrate any of the reasons for remanding Adult B in custody on the 11th April 2012. Despite the devastating and tragic circumstances that followed, Devon and Cornwall Police were justified in remanding him on bail.

CCTV at Sheltered Accommodation

223) C3 specifically requested that the Panel look into why CCTV was not routinely installed at the Sheltered Accommodation Unit where Adult A resided with other elderly residents. Had Adult A died on the night of the assault, C3 believes that it would have been very difficult to prove that Adult B entered the property.

224) The DHR sought a response from Cornwall Housing and received the following reply;

Cornwall Housing has not invested in CCTV in its sheltered housing scheme for several reasons;

- *In the main these scheme were built in the 70's, 80's and 90's, and often the design and layout of the building is not conducive to CCTV coverage, i.e. there are often multiple points of access / entry to the building, which would be difficult to cover appropriately with a CCTV system. The original construction of these building also did not include CCTV.*
- *There is also a cost for installation, management and maintenance of CCTV systems, which has not been considered as a priority within these schemes. Cornwall Housing has invested heavily in many of these sheltered housing schemes similar to REDACTED but the improvements which have been made*

usually enhance the living conditions, such as better kitchens and bathrooms for tenant's flats, or improved common room facilities.

- *On many similar sheltered housing schemes door entry systems have been installed, but these are only as good as the tenants / residents using the building, as there are instances where doors are propped open by residents, negating the effectiveness of such a system.*

- *It is a requirement for housing providers to liaise with their tenants about the improvements which are being undertaken, CCTV has occasionally been discussed at residents meetings in these schemes, but there has not been a desire for wide spread use of CCTV to improve their security. When CCTV has been discussed many residents have felt that it would be too expensive and too intrusive and would have preferred for the money or budget to have been used for other purposes.*

- *CCTV isn't conducive to the overall impression of the scheme – we would not wish to have created an environment where residents have felt it was necessary to have CCTV in operation in corridors and stairwells.*

- *Increased management time / resources - we have only a few examples where we have installed CCTV on Council Estate, as the use of CCTV is strictly monitored and subject to regulation, so where we do have CCTV, we have needed to erect signs, control the access to images, and to be clear about the reason for installation of CCTV and its use.*

- *It is for a mixture of these reasons above, which may vary on a scheme by scheme basis, that Cornwall Housing has not considered the installation of CCTV; neither do we have plans for installing CCTV in the near future.*

225) The Panel is aware that this reply may not be the response that C3 was hoping for. Whilst CCTV would have been beneficial in identifying Adult B on the 17th April 2011, the Panel acknowledge that a CCTV system was unlikely to have prevented Adult B from entering the property, and would have only been effective at preventing the assault if it was supported by live monitoring.

Information on Mephedrone

226) C4a expressed her frustration with the lack of information available through the family G.P and other statutory agencies on the specific drug Mephedrone saying that the family had to conduct their own on-line research about its risks and side-effects.

227) Mephedrone, dubbed *'the poor man's cocaine'* by local media[12], first came to public notice in 2009 when it was sold as a 'legal high' in 'head shops' and online. It quickly became a concern for the Government after a number of high profile Mephedrone related deaths[13]. The drug was banned on the 16th April 2010 and is now categorised as a Class B drug under the Misuse of Drugs Act 1971. Whilst the new law has driven the drug away from the 'head shop' scene, a Drugscope survey of drugs workers at the end of 2012 reported that Mephedrone use was still widespread in the UK with a worrying increase of problematic intravenous users.[14]

228) The dangers of Mephedrone were emphasised within the Cornwall and Isles of Scilly Drug Related Deaths Annual Report (2012) which identified one Mephedrone-related death in January 2012[15]. Records from The National Programme for Substance Abuse Death (npSAD) also identified 70 deaths in 2011 where Mephedrone was detected as being present within toxicology results. In 30 of these cases Mephedrone was suspected to be the primary cause of death[16].

229) The Independent Chair was able to find up-to-date information about Mephedrone on the National FRANK[17] website which includes a telephone helpline for concerned users or family members. The Cornwall Drug and Alcohol Action Team (DAAT) also advised the Independent Chair that information on Mephedrone was accessible locally through the Safer Cornwall webpages,

[12] http://www.thisiscornwall.co.uk/Legal-highs-banned-month/story-11385846-detail/story.html#axzz2rJfYlLbF
[13] http://www.dailymail.co.uk/news/article-2316621/Mephedrone-deaths-Emma-Johnston-Chris-Goodwin-die-taking-lethal-cocktail-bubble.html
[14] Daly, M. (December 2012). "'Drone Strikes". *Druglink*. Drugscope. pp. 8–11.
[15] www.cornwall.gov.uk/idoc.ashx?docid=c339a471-3510-4c19...1
[16] www.cornwall.gov.uk/idoc.ashx?docid=c339a471-3510-4c19...1
[17] http://www.talktofrank.com/search/apachesolr_search/mephedrone

DAAT, Addaction[18], GPs, schools and colleges and YZUP young peoples' services[19].

230) Specifically the Independent Chair was informed that YZUP provided school and college based education programmes across Cornwall to raise awareness of the dangers of drug use. This is arranged by individual schools on an ad hoc basis. DAAT also added that they are in the process of setting up a library of evidence-based resources endorsed and recommended by Children, Schools and Families and Public Health.

231) The Independent Chair was unable to substantiate whether specific information was available within G.P surgeries, schools and colleges and YZUP when C4a was looking for local support in 2010. At the time of this report, there was no information on the Safer Cornwall website as suggested; however, Addaction was a good source of local information and provided advice and telephone numbers for concerned family and friends.

232) It would not be unreasonable for a reader to ask why Adult B's G.P did not dual refer to a drug and alcohol support service at the same time Adult B was referred for a mental health assessment, especially given that;

a) Information on Mephedrone was supposedly available within G.P surgeries in 2010.[20]

b) Adult B was eligible for the YZUP Service.

c) The YZUP project was funded by the Cornwall & Isles of Scilly Primary Care Trust and seeks to *'provide a proactive and holistic approach to tackling underlying health problems by linking health professionals, health based organisations and individuals through a GP Recommendation Scheme'.*[21]

233) A couple of explanations could be possible;

a) The G.P responded to the changes in Adult B's behaviour and referred firstly to Mental Health Services to determine whether the behaviour was an

[18] http://www.addaction.org.uk/page.asp?section=222&search=#mepha
[19] http://www.wchlc.org.uk/getproject.cfm?code=199
[20] According to the information provided by DAAT on the 19.01.2014
[21] http://www.wchlc.org.uk/About/about.cfm

indication of an underlying mental health condition, potentially exacerbated by his use of drugs and alcohol.

b) In 2010 The Cornwall Foundation Trust was the provider of Drug and Alcohol Services and Mental Health Services (they are now different providers). The GP may have assumed that an onward referral to Drug and Alcohol Services would be made if it was established that Adult B did not have an underlying mental health condition;

234) A person presenting with possible psychosis, who is also misusing substances, can pose a diagnostic and management challenge for clinicians in that they must try to differentiate between three different phenomena with regard to the suspected psychosis and substance misuse. i.e.;

- People can experience an acute psychotic episode in response to substance intoxication, withdrawal and use due to the effects of the substance.

- Substances can precipitate a psychotic disorder in predisposed individuals which can persist in the absence of the psychoactive substance.

- Some people have an underlying psychotic disorder that is exacerbated by combined use of substances, in particular cannabis and amphetamines

235) It is feasible that Adult B's GP sought to address what she considered to be the greatest risk at the time. She made a referral to Mental Health Services for an assessment to determine whether Adult B had an underlying mental illness which required mental health intervention and treatment.

236) In terms of Adult B's Mephedrone use, a referral to Drug and Alcohol Services from Mental Health would only be made if it was identified as required. Adult B acknowledged his use of Mephedrone and provided insight into its impact on his behaviour, sleep, concentration and diet. He also demonstrated insight into his understanding of the use of this substance and its negative impact on his wellbeing. He provided assurance that things had improved and he was no longer using. At this point there was no reason for Mental Health Staff to make an onward referral to drug and alcohol services.

237) The assessment found no evidence of mental illness, however, as a precautionary measure, due to his age; the Mental Health Team appropriately referred Adult B to the Early Intervention Service to consider the possibility that Adult B might have an emerging first presentation of a psychotic disorder. This was good practice and evidence that staff were being thorough.

238) The Chair acknowledges C4a's disappointing that she did not feel she received adequate local support for Adult B's drug use, which she feels may have helped her to assist and support her son. Good practice, in future, would be for General Practitioners to source information online during the consultation and to ensure that the patients (or concerned relatives) understand the purpose of any referrals and possible outcomes. Patients should also be encouraged to revisit the GP surgery if they continue to have concerns.

239) NOTE: Despite intensive investigations, the Independent Chair was unable to locate the service that C4a referred to as offering *'a light touch'* approach to Adult B's Mephedrone use. It would be unreasonable for the Panel to add an analysis of a service or its adopted approach without having the benefit of discussions with the Professionals involved.

Conclusions

Were family members aware of any previous abusive behaviour from the perpetrator to the victim?

240) From the information provided by the family, there is no evidence to suggest that any family member was aware of any previous abusive behaviour from Adult B towards Adult A.

241) The family did not express any concerns for the safety of Adult A in Adult B's company and each described the relationship as a good relationship.

242) Although both F3 and F4 family members were aware of Adult B's drug use, they had no reason to believe that Adult B would harm Adult A, either to obtain drugs or whilst under the influence of drugs. The family could not have foreseen the events of the 17th April 2012.

Were there any barriers experienced by the family in reporting any abuse or concerns in Cornwall or elsewhere, including whether they (or the victim) knew how to report domestic abuse had they wanted to?

243) As no family member suspected domestic abuse from Adult B towards Adult A the question of 'barriers to reporting abuse' is somewhat inapplicable.

244) In terms of Adult B's drug use, each side of the family seemed to be aware of Adult B's deterioration leading up to the homicide. Whilst Adult B's behaviour did not elicit significant concerns for Adult A and C3, his parents C4 and C4a did report their son to the police and family G.P[22]. This would suggest that C4 and C4a did not encounter any barriers to reporting concerns despite the difficult moral dilemma of reporting their own child to the Police.

[22] Missing person. Vehicle theft. Drugs misuse

SECTION FOUR

SECTION FOUR: ANALYSIS OF INDIVIDUAL MANAGEMENT REVIEWS

245) The focus for this section of the report will be an analysis of the response of *Services* involved with Adult A and Adult B; why decisions were made and actions taken or not taken.

246) Any issues or concerns identified are a reflection of the evidence made available with the benefit of hindsight and the application of foresight.

Hindsight bias

247) Hindsight bias can lead to grossly overestimating how obvious the correct action or decision would have looked at the time and how easy it would have been for an individual to do the right thing. It would be foolhardy not to recognise that a review of this type will undoubtedly lend itself to the application of hindsight and that looking back to learn lessons often benefits from such practice. That said, the Review Panel has made every effort to avoid hindsight bias and has viewed the case and its circumstances as it would have been seen by the individuals at the time.

248) The Review Panel has considered the way in which agencies and individuals responded to the family in the context of domestic abuse services accessible and available to victims during the period stated in the scope of the review.

249) All of the agencies involved in this review provided candid accounts of their involvement in order to learn lessons.

DEVON AND CORNWALL POLICE INDIVIDUAL MANAGEMENT REVIEW

250) The IMR Author has undertaken an analysis and an unbiased critique of Devon and Cornwall Police involvement with Adult B and the key events in the period covered by this Domestic Homicide Review. It does not detail all contact with Adult B outside of the scope of the review. Comprehensive information may be found in the tabular chronology. (Appendix A).

251) The appointed IMR Author is employed by Devon and Cornwall Police as a Review Officer with over seventeen years' experience in front line policing, crime investigation, strategic support and public protection.

Summary of Involvement with Devon and Cornwall Police

252) At 1650 hours on the 28th of February 2010 Adult B was reported missing by his mother (C4a). She reported that he had been in (REDACTED) with a group of friends the previous evening and had been last seen near a nightclub when his friends left to go home by car at 2330 hours. A COMPACT (Community Policing and Case Tracking System) report was completed at 1720 hours, risk assessed as medium. The reason specified on the COMPACT record was that it was out of character for Adult B not to make contact with his family.

253) Additional information was phoned in to Devon and Cornwall Police by Adult B's mother on the same day to report that one of his friends believed he was in a Travel Lodge in the area. As a result Adult B's parent's stated that they would travel to (REDACTED) to check the hotels. Approximately an hour later they called again to say that they had checked the hotels and Adult B had not checked into any they could find.

254) A short time later the Manager from a local Hotel made contact with the Police to report that Adult B had checked in at 0115 hours that morning but had requested that under no circumstances should staff disclose that he was there. There was a comment that staff had noticed a lot of cash lying around in his

room.

255) A Police Unit was despatched to check on Adult B. In the meantime, his father C4 came into the (REDACTED) Police Station to speak to an Officer, stating that he was not convinced that staff at the Travel Lodge had told him the truth about Adult B's whereabouts and that he was concerned for his son's state of mind; having recently found out he had been bullied at work.

256) The responding Police Officer spoke to Adult B at the Hotel and ascertained that he was happy to speak to his Father. The Officer returned to the Police Station and spoke to C4 who then went to see Adult B. There was no further Police involvement and the Police COMPACT record was finalised.

257) There were a number of items of intelligence in relation to Adult B and his drug taking recorded during 2010. These were submitted by a local PCSO as a result of information passed to him by family members and associates. There was no direct involvement by Police in any of the incidents described (below), apart from a reference to when he was located in Plymouth following the missing person report (above).

258) The first report was on the 19th of March 2010 and it referred to NB (NB is the ex-partner of one of Adult B's cousins) attending the family home and demanding that Adult B repay him a loan of £100. It was recorded that Adult B's father C4 had shut the door on NB but had advised Adult B to repay the money.

259) The next report was dated on the 20th of March 2010 and it described that Adult B had been experiencing psychotic episodes since taking 'Bounce' over Christmas. It was believed that he had obtained the drugs from NB. The report stated that he had been rescued from a Hotel in (REDACTED) and had been found sitting in the middle of the road talking to a paper bag. There was a comment that Adult B was being treated by his GP and it was thought he would recover from this in time.

260) The final intelligence report was dated the 21st of March 2010 and it stated that Adult B had paid NB the £100 for buying Mephedrone and that they were now on speaking terms.

261) Following the intelligence submissions there was no contact with Adult B until he turned 18 and was involved (with his cousin C2b) in an assault on a 15 year old male on the 27th of July 2011 (16 months later).

262) The 15 year old victim knew both Adult B and C2b. The incident occurred in the street at 2130 hours at night. The victim was grabbed by Adult B, and held by the arms, while C2b punched him in the face leaving him with a cut lip which required stitches. The victim stated that he had made derogatory comments prior to the incident about Adult B's size and earlier about C2b being a 'paedophile'. Both Adult B and C2b were arrested on the 31st of July 2010 and they admitted to the assault. They were both charged to court on the 7th of August 2011 and pleaded guilty to common assault. Adult B received a conditional discharge and was ordered to pay £85 costs and £50 compensation.

263) There was no further contact with Adult B until the 11th of April 2012 when C4 reported at 0419 hours that his car had been stolen within the last 10 minutes. At approximately 0450 hours a police vehicle located C4's car being driven by Adult B. Adult B was in company with another three males. He was arrested after providing a positive roadside breath test. He later provided a sample of breath which was 52 micrograms of alcohol in 100 millilitres of breath. The limit is 35 micrograms of alcohol in 100 millilitres of breath, therefore, Adult B was charged with drink driving. His parents confirmed that he had not been given permission to drive the vehicle and gave a statement to Police. Adult B was a provisional licence holder at the time.

264) In interview Adult B stated that he had been out with friends drinking and at 0330 hours had decided to return home to collect his parents' car to take his friends into (REDACTED) to purchase some food (25 miles away). Adult B admitted to drinking 3 to 4 cans of lager. He was convicted on the 17th of May 2012 of aggravated vehicle taking, driving with excess alcohol, driving otherwise

than in accordance with a licence, no insurance and breach of a conditional discharge.

265) The arrest and interview of Adult B for this incident was the last contact Police had until he was arrested for the assault on his grandfather Adult A on the 17th April 2012.

Analysis of contact with Devon and Cornwall Police

266) Although Devon and Cornwall Police had a number of separate interactions with Adult B during the scope of the review, there were never any direct reports or third party concerns for domestic abuse between Adult A and Adult B during any timeframe leading up to the Homicide. Due to this, Devon and Cornwall Police were not obliged to undertake a risk assessment in accordance with the Force Policy for Investigating Domestic Abuse.

267) Looking specifically at the escalating behaviour of Adult B during the scope of the review, Devon and Cornwall Police did hold some third party intelligence to suggest that his behaviour was affected by Mephedrone use, however there was no clear pattern to his offending and direct contacts with Devon and Cornwall Police were intermittent. Given this, it is unlikely that Adult B's offending history would have raised significant concern or led the Police to fear for the safety of others.

268) The IMR Author interviewed the local PCSO patrolling the neighbourhood where Adult B resided with his family between 2010 and 2012. He was aware of Adult B and his family through regular foot patrols of the estate. He recalled that Adult B often consumed alcohol with friends but this was not a regular occurrence nor was it unusual for children of his age (16/17 years) to drink alcohol in the local community. Therefore, Adult B was not identified as a person of significance or a cause for concern during the years that the PCSO knew him.

269) The PCSO stated that Adult B would often associate with children younger than him and was *'more a follower than a leader'*. He was sometimes unable to

articulate the reasons behind his anti-social behaviour. This statement supports C4a's (Adult B's mother) belief that Adult B was *'very gullible and succumbed to peer pressure'*.

270) The PCSO considered Adult B's parents to be very supportive on the occasions that he communicated with them and regarded the family as hard working. They were not a problematic family for the Neighbourhood Beat Teams.

271) Devon and Cornwall Police held no record of any kind to indicate that Adult B was a risk to himself or others. His involvement in the assault of a 15 year old boy in 2011 did not implicate him as the instigator of the violence. The drink driving incident in 2012 could be considered as presenting a risk to others by causing an accident, however, this was dealt with by arrest and conviction and loss of licence.

272) Adult B did not meet the threshold for the Youth Offending Service, although each contact Adult B had with Devon and Cornwall Police, under the age of 18, should have prompted a 121a Police Notification Form. The 121a process is a system for gathering information relating to all children and young people under the age of 18 years *'coming to notice'* of Police. It is not a direct referral to Children's Services, but a record of Police contact with children and young people. The 121a's submitted by Officers are downloaded daily by 121a Evaluators who research the child and family and add value (i.e. any other concerns or issues to inform any assessment of risk) before sending the information on to Children and Young People's Services, Health and Education, usually within 48 hours.

273) In this case there was no compliance with the 121a process on two occasions when Devon and Cornwall Police had contact with Adult B before his 18th Birthday. The first occasion was when he was served a Stage 2 Anti-social behaviour letter (outside of the scope of this review) and a second occasion when Adult B was found and seen by Police following a Missing Persons Report.

274) This was an omission by the Police Officers involved. During interview, both Officers were surprised that they had not completed a 121a as this is routine practice that they are accustomed to. The IMR author stated that historically Officers were occasionally thrown by a 'grey area' between the Police and Criminal Evidence Act (PACE) 1984 which defined a child as under 17 (not 18) and HM Government (2013) Working Together to Safeguard Children[23] Guidance that defines a child as anyone who has not yet reached their 18th birthday.

275) When Adult B checked into a hotel without relying on his parents for accommodation, money or care, it is likely that the responding Police Officer assumed Adult B to be an adult in line with the Police and Criminal Evidence Act (PACE) 1984 in place at the time.

276) Although there is no single law that defines the age of a child across the UK, the UN Convention on the Rights of the Child, ratified by the UK government in 1991, states that a child "means every human being below the age of eighteen years".[24]

277) Given that Adult B was 17 years old when he was reported as a missing person, and was not arrested on suspicion of an offence, he should have been classed as a child under Article 1 of the UN Convention on the Rights of the Child. This should have alerted Police Officers to their Child Protection obligations and the Force Policy to complete a 121a Police Notification Form for Children's Services.

278) On the 23rd October 2013, Code C of the Police and Criminal Evidence Act (PACE) 1984 was amended so that 17-years-olds are no longer treated in the same way as adults aged 18 and over. The Act now states that 17 year olds are children and are entitled to an appropriate adult. This change should now remove the confusion for Officers and a 121a Police Notification Form should be

[23] HM Government (2013) Working together to safeguard children: A guide to inter-agency working to safeguard and promote the welfare of children

[24] Article 1, Convention on the Rights of the Child, 1989.

routinely completed for all 17 year olds *'coming to the notice of Police'.*

279) Other than the oversight of the 121a process, the Police response to the Missing Persons Report was in line with Force Policy and National Standards of Good Practice[25]. A COMPACT (Community Policing and Case Tracking System) report was completed immediately when Adult B was reported missing by C4a. As it was out of character for Adult B not to make contact with his family, the case was risk assessed as medium.

280) In response to Adult B's missing person report, the Duty Inspector was informed as standard practice, along with the CCTV control room for Plymouth. Officers also initiated 'ECABUS' which is a Plymouth missing person cascade system for informing bus and taxi companies with the description of persons reported missing.

281) In accordance with National Best Practice Guidelines[26], it is standard practice to undertake a risk assessment for all persons who are the subject of a missing person report. In relation to Adult B, two comments on the incident log are of note;

a) **Is there any indication that the person is likely to commit suicide?**

Answer from Parents; *"State of mind - typical teenager, mixed up and muddled, has a job he doesn't like".*

b) Does the Person have a physical illness or mental health problem?

Answer from Parents; *"Found out a couple of weeks ago that he had been on 'Bounce', thought that was sorted out as he had an adverse effect, Alcohol not an issue".*

[25] The National Centre for Policing Excellence (NCPE), established by the Police Reform Act 2002 (now the National Police Improvement Agency NPIA), has produced national guidance on behalf of ACPO entitled "Guidance on the Management, Recording and Investigation of Missing Persons".

[26] The National Centre for Policing Excellence (NCPE), established by the Police Reform Act 2002 (now the National Police Improvement Agency NPIA), has produced national guidance on behalf of ACPO entitled "Guidance on the Management, Recording and Investigation of Missing Persons".

282) The first answer is somewhat different to the account C4 provided to Officers when he attended (REDACTED) Police Station in (REDACTED) later that evening. During this discussion C4 stated that he was concerned for his son's state of mind; he had found out he had been bullied at work and with one bully holding Adult B against a wall with a knife to his throat.

283) The Police Constable who found Adult B at the hotel on the evening of the 28th February 2010 was interviewed as part of this Domestic Homicide Review. He recalled speaking to Adult B about the concerns C4 had expressed at the Police Station. He stated *'I did speak briefly with Adult B in regards to the statements made by his father. He categorically denied being threatened by anyone with a knife at his work but did say he had been subject to some initiations.'*

284) The Panel is unable to speculate on why there is a discrepancy between Adult B's view of his workplace and the bullying concerns raised by C4. It could be that Adult B was concerned about Police involvement and therefore minimised the 'knife threat' due to fear of retaliation. It is difficult to know if this alleged incident ever took place or if it had any impact on Adult B's behaviour at that time. It seems to be unrelated to other intelligence held by Police and is unlikely to be a contributing factor in the death of Adult A.

285) The second answer (see 281) includes parental concerns that Adult B had resumed his use of 'Bounce' (Mephedrone). Since this case has focused on Adult B's use of Mephedrone leading up to the homicide, the Review Panel were keen to explore whether there was an opportunity to intervene or offer support on any of the occasions when Adult B had contact with Devon and Cornwall Police, and specifically when he was arrested and taken into custody for driving under the influence of alcohol (on the 11th April 2012).

286) Principally the Panel asked if an Exit Risk Assessment Referral was completed to the Drug & Alcohol Arrest Referral Team when Adult B was held in custody at REDACTED Police Station on the 11th April 2012.

287) The Panel received the following response from Devon and Cornwall Police;

288) 'When Adult B was arrested for Drink Driving he was asked risk assessment questions and denied that he was dependant on alcohol or drugs. He was asked about a referral for alcohol which he declined. He admitted to drinking 3 cans of lager and the amount of alcohol recorded in his breath was not exceptionally high. His reading was 52 and the limit is 35, it is not unusual to have readings above 100. The Plymouth custody have confirmed that the referral is on a consensual basis so if the person did not agree, even if there were significant concerns, they would not make a referral. This is also confirmed by the Custody Nurse who will often see people under the influence of alcohol to assess if they are fit to detain. Even when they have concerns they require the persons consent to make a referral. In Adult B's case he was not referred to the Custody Nurse as he was not perceived to be very drunk'.

289) 'In relation to the Assault Offence in 2011, Adult B was asked the same risk assessment questions. When interviewed Adult B stated that he had drunk alcohol during the evening leading up to the offence but did not consider himself to be drunk describing that on a scale from 0 to 10 (10 being very drunk) he was 1. He would only have been referred to the Custody Nurse if he had expressed a health concern. There is nothing recorded to indicate that he admitted to any drug or alcohol problems but it does state that he had been drinking the night before his arrest. Adult B did not have a significant criminal history to have alerted a serious concern about his behaviour but it is assumed that on conviction for the assault he would have had Probation involvement'.

290) It appears that on both occasions Adult B denied using illegal drugs and minimised his consumption of alcohol. There is a possibility that the environment (a custody suite) and timing was not conducive to an honest admission, or, Adult B may have genuinely believed that his use of drugs and alcohol was not problematic and therefore did not consider treatment, or support, as an option.

291) It is extremely unlikely that an individual will give up a particular behaviour if they do not feel any need to do so. For change to occur at this specific time,

Adult B would have needed to recognise the need for support and be a willing participant. In order for Adult B to escape his subsequent downward spiral he would have had to have been agreeable and motivated to access support. The Custody Officer and the Custody Nurse would not have been able to refer Adult B to the Drug & Alcohol Arrest Referral Team without Informed Consent.

292) Informed consent most usually refers to a process whereby an individual consents to a proposed treatment or procedure because they understand that it would benefit them to do so. Informed consent is a legal procedure to ensure that a person is aware of all the potential risks and costs involved in treatment or support. Adult B was informed about the consequence of a referral to the Drug & Alcohol Arrest Referral Team and expressed his right to decline the referral.

293) Devon and Cornwall Police do not appear to have assessed Adult B for Drug-Driving on the 11th April 2012. Whilst Adult B failed a roadside breath test, there is no mention of whether Adult B failed or passed a Field Impairment Assessment (FIA).

294) Prior to 2013 a Field Impairment Assessment was the only method available to Officers to identify those driving under the influence of drugs. The FIA was administered by trained officers at the roadside and was based on five field impairment tests to observe impairment. In January 2013 (some 9 months after the homicide of Adult A) the Home Office approved the Dräger Drug Test® 5000 System[27], an analyser and test kit to provide fast and accurate on-site drug detection. Substances such as opiates, cocaine, cannabinoids, amphetamines as well as designer drugs and tranquilizers based on benzodiazepines can now be detected in oral fluid samples, taken from a mouth swab.

295) It would be expected practice today, given the previous Police intelligence for Mephedrone use, that Devon and Cornwall Police would assess Adult B for Drink Driving and Drug Driving. That said; it is doubtful that a positive test for Drug Driving would have changed the decision to remand Adult B on bail.

[27] http://www.draeger.com/sites/en_aunz/Pages/Alcohol-and-Drug-Detection/Draeger-DrugTest-5000.aspx

Conclusions

296) To conclude, Devon and Cornwall Police has three separate contacts with Adult B (plus intelligence surrounding his use of Mephedrone) leading up to the homicide. The last contact with Adult B was just 6 days prior to the homicide of Adult A. Whilst the Chair can appreciate that this could be viewed as a crucial point where intervention could have played a part in prevention, the Officers were restricted by criteria set out by the Bail Act of 1976 and made the right decision to remand Adult B on Bail. There was no indication of risk on the 11th of April 2012 to warn Police of his subsequent actions on the 17th April 2012.

297) The omission by two Officers to complete a 121a Police Notification Form is evidence that this process was not always applied consistently across the Force at the time. The 'grey area' between the Police and Criminal Evidence Act (PACE) 1984 and the HM Government (2013) Working Together to Safeguard Children[28] Guidance no longer exists; therefore it remains the responsibility of Devon and Cornwall Police to ensure all Officers are compliant with Force Policy and the requirement to consistently complete a 121a for all children and young people, under 18 years of age.

298) The Chair has considered whether this oversight would have had any bearing on the outcome of the tragedy that followed. Not only did the 121a's relate to incidents that occurred two years prior to the homicide, each incident would not have met the significant harm threshold[29] for Children's Services (then or now). Whilst this does not excuse the oversight, it does highlight that a 121a is not a child safeguarding alert and therefore is not a guarantee of Children's Services intervention. As the Officers did not raise a separate safeguarding alert, they did not believe Adult B to be at significant risk of serious harm, or consider him to be a significant risk to others. It is improbable that the submission of 121a's in this

[28] HM Government (2013) Working together to safeguard children: A guide to inter-agency working to safeguard and promote the welfare of children
[29] Identified within the Children's Act 1989

case would have changed the future course of Adult B's actions.

299) Overall, Devon and Cornwall Police could not have foreseen what would happen on the 17th April 2012, nor would they have been in any position to change the course of that action within the remit of the law.

CORNWALL FOUNDATION TRUST (CFT)
Individual Management Review

300) Cornwall Partnership NHS Foundation Trust is an NHS provider Trust responsible for Mental Health, Learning Disability and Children and Young People Services. The Trust took responsibility for Children's Community Health Services in April 2011.

301) The IMR Author for the Cornwall Foundation Trust is a Registered Nurse in Mental Health RMN and a Registered Nurse for Learning Disability RNMH with over 34 years' experience of working in the NHS in both in both managerial and clinical roles.

302) The IMR Author undertook an analysis of the documentation and notes relating to Adult B and interviewed the Community Mental Health Team (CMHT) Manager, Early Intervention Team Manager, Chief Operating Officer for Cornwall Foundation Trust (CFT) and a review of CFT Policies linked to the issues raised within this Domestic Homicide Review.

Summary of Involvement with Cornwall Foundation Trust

303) On the 2nd March 2010 a verbal referral was received from a GP to North Cornwall Community Mental Health Team in Cornwall Partnership Foundation Trust (CPT) (Now Cornwall Foundation Trust CFT). At the time, this team was responsible for all assessments on young people aged 16 years and over.

304) A screening / referral form was completed. The referral details were recorded as follows;

'No previous history. Always been quiet and shy. Took 'Bounce' a few weeks ago and has become very strange. Disappeared to a (REDACTED) and his parents found him and he stated that 3 people were watching him. Was found

also at (REDACTED) and he stated the two people were watching him and there was no one around, also was outside talking to a paper bag. Is currently at work, although he has been bullied there and has been missing days'.

305) The outcome of the screening was for Adult B to be seen for assessment by the North Cornwall Mental Health Team.

306) On the 3rd March 2010 a front sheet was completed to set up Adult B's mental health notes. Adult B was seen for an assessment on the same day by a Student Nurse and a Community Psychiatric Nurse. (Both staff members have since left the service).

307) The assessment covered the full range of areas outlined on the core assessment document;

- Background to Referral
- Social/Employment
- Finances
- Drugs and Alcohol
- Personal History
- Risk History
- Mental State Examination
- Action Taken

308) The Assessment records the following notes under each heading;

309) **Background to Referral**

a) *'Taking of 'Bounce' and the impact on him of feeling people are watching him, he called his father as he was panicky, his mother had observed odd behaviour of his, such as talking to a paper bag'.*

b) *'Adult B cannot remember any of this. Poor memory down to tiredness and described preferring to sleep during the day and to go out with his friends at night. Finding it hard to get up in the morning, napping during the day and then up most of the night'.*

c) *'Poor concentration while playing video games on TV, at work and in general. No motivation, Poor appetite, snacking during the day and replacing food with energy stimulant drinks and coffee. Poor dietary intake and some allergies to food'.*

d) *'No previous psychiatric history, no current medical history and no taking of any medication'.*

310) **Social / Employment**

a) *'Lives in the family home'*
b) *'Full time job at (REDACTED) on the (REDACTED); does not like his job, but hard to find full time employment at 17yrs old. Would like to be a mechanic and has considered link to learning to improve academically'*
c) *Enjoys working with engines and had rebuilt motorbikes and cars. Plays football, plays pool and goes to the pub with friends. Has a provisional driving licence'.*

311) **Finances**

a) *'Wages paid into Mums account which was agreed by Adult B to help him manage his finances'.*

312) **Drugs and Alcohol**

a) *'Will drink as much as he can afford'*
b) *'Smoked 'weed' but does not like it'*
c) *'Taken Bounce once which resulted in ulceration of the nose, has noticed differences in himself, poor sleep and people watching him'*

d) *'No other drug use reported'.*

313) **Personal history**

a) *'Happy childhood, close to sister, things changed at secondary school, was bullied and did not enjoy academia'*
b) *'Had wrist and fingers broken by other pupil and was then disciplined for verbally racially abusing his attacker. Does not like violence and would not harm himself'*
c) *'Assaulted on 26/02/10, tooth broken and he walked away, would not fight back'*
d) *'Does not enjoy work and had some issues with bullying there at first but this was sorted out now'*
e) *'Mum and dad live in the family home'*
f) *'Dad (REDACTED), mum works in a (REDACTED) so was always there for children in holidays and family life was happy'*
g) *'Sister 14 years old, has close relationship'*
h) *'Older brother 27yrs, Adult B thinks his brother does not like him'*
i) *'Granddad (ADULT A), had a close relationship until recently when Adult B was accused of stealing money, this affected their relationship'*
j) *'Adult B stated he thinks his mum thinks he is stupid and that he does not talk to his parents much'.*

314) **Risk History**

a) *'No identified risk of harm to self or others'*
b) *'Had community police involvement when he (REDACTED)*
c) *'Has no criminal record'*

315) **Mental State Examination**

a) *'Fidgety, poor eye contact, normal rate tone and volume of speech'*
b) *'Mood does not appear low, no low mood reported'*

c) *'No ideas of reference, voices or olfactory hallucinations reported'*
d) *'Cannot remember talking to the paper bag, does not know why he would not remember'*
e) *'States he will sort things out himself'*
f) *'Poor sleep napping in the day, awake at night – vague as to why he cannot sleep'*
g) *'Poor diet - drinks energy drinks'*
h) *'Changes in behaviour and experiences since taking 'bounce approx. one month ago, poor sleep pattern, poor appetite'.*

316) Despite no evidence of mental illness or altered perceptions, a referral was made to the Early Intervention Service as a precautionary measure due to Adult B's age. The Early Intervention Team provide support for people aged 14 to 35 years experiencing a first episode of psychosis (see 'psychosis' definition 333) below) and it was hoped that this team would have a second opportunity to assess whether Adult B had an emerging psychotic disorder which could have triggered his strange behaviour (described by C4a at the G.P Surgery).

317) On the 4th March 2010, a letter was sent to Adult B's GP with the outcome of the mental health assessment. The letter notes that apart from the experiences Adult B described there were no other altered perceptions raised. Although it was never confirmed one way or another whether Adult B's strange behaviour was as a result of his illicit substance use, he was able to identify a negative impact since taking the substance. However as a precautionary measure due to his young age, the CPN still believed that a referral to a specialist service to consider a first presentation of a psychotic disorder was warranted. This was good practice.

318) A copy of this letter was sent to Adult B and his family.

319) An Internal referral was made to the Early Intervention Service on the same day (4th March 2010).

320) On the 10th March 2010, the Early Intervention Service sent a letter to Adult B inviting him to attend an appointment on the 12th March 2010 at (REDACTED) in (REDACTED).

321) On the 12th March 2010, a Community Psychiatric Nurse (CPN) from the Early Intervention Service (EIS) telephoned Adult B on his mobile to ask him to call to confirm whether he would be attending the appointment. The call was not returned and Adult B did not attend the appointment.

322) Later that day, the CPN sent a letter to Adult B offering another appointment for the 17th March 2010 at (REDACTED) in (REDACTED).

323) On the 17th March 2010 the CPN from the Early Intervention Service records that Adult B did not attend the scheduled appointment. The CPN attempted to make contact with Adult B and C4a.

324) On the 25th March the CPN from the Early Intervention Service made a telephone call to Adult B's mother (C4a) in response to her telephone call to re-arrange the appointment. There was no answer at the family home. The CPN left a message on the answer phone.

325) On the 14th April 2010 the CPN from the Early Intervention Service sent a letter to Adult B to enquire whether he still wanted an assessment. The letter stated *"If we do not hear from you within 3 weeks of the date of this letter, we will presume that you no longer wish to be seen. If however you experience a similar problem in the future you can self-refer to our service at any time".*

326) On the 12th May 2010, the CPN from the Early Intervention Service made a telephone call to Adult B's mother (C4a) to enquire how Adult B was and to ask if he would like another appointment to meet with the Early Intervention Service. The CPN recorded;

a) *'C4a stated that Adult B was now back to his normal self and had stopped taking "Bounce"*. *C4a believes that Adult B's problems were due to taking*

'Bounce' for a few months over the Christmas period which produced his symptoms. Adult B had been 'hanging' around with a different crowd over that period which had encouraged him to take drugs. Mother believes Adult B can see the effects of drugs on his mental health and has since stopped taking them. C4a said that Adult B had been unwell for a period of 3 months before starting to recover. Adult B had been angry with her for referring him to mental health services. C4a intended to speak to Adult B about the possibility of meeting with the Early Intervention Service for an assessment'.

327) The CPN agreed to send out an Early Intervention Service information leaflet to help with these discussions. The CPN also offered to meet with C4a to discuss issues if required, although much of this was addressed via the lengthy telephone call on the same day (12th May 2010). The CPN followed up this conversation by sending out a letter and a leaflet about the Early Intervention Service to help C4a approach a discussion with Adult B.

328) On the 1st June 2010, the CPN from the Early Intervention Service made a telephone call to C4a as she had not phoned back as agreed or returned previous calls. A message was left asking C4a to contact the CPN.

329) A Multi-Disciplinary Team Meeting was held during the week of 1st June 2010. The decision was made to send a letter advising Adult B of discharge if no contact was received following the message left on the 1st June 2010.

330) On the 7th June 2010 a letter was sent to Adult B advising of his discharge from the Early Intervention Service. The letter read;

a) *"Further to your referral to our service, we have unfortunately been unable to meet with you. As a result of your non-attendance at arranged appointments I am presuming that things are now working out well for you. If however you find that you have any difficulties in the future and would like another assessment, we would be more than happy to offer you another appointment at your convenience. For the time being however, we are treating your non-attendance as an indication that things are currently well and do not plan on*

any further contact at this time. I have copied in your GP and family to this letter so that they are aware of the situation"

331) On the 8th June 2010 Adult B was discharged from the Early Intervention Service with an open invitation to contact them if he needed to do so in the future. This was last contact Cornwall Foundation Trust had with Adult B.

Analysis of contact with Cornwall Foundation Trust

Mental Health and Drug Use

332) For non-medical readers the Chair has included a description of 'Psychosis' below;

333) Psychosis is a medical term used to describe an experience of distorted reality which may impact on a person's thinking and behaviour.[30]

334) The two main symptoms of psychosis are:

a) **Hallucinations** – where a person hears, sees (and in some cases smells) things that are not really there; a common hallucination is when people hear voices in their head;

b) **Delusions** – where a person believes things that, when examined rationally, are obviously untrue; such as believing that your next door neighbour is secretly planning to kill you[31].

335) The combination of hallucinations and delusional thinking can cause an often severe disruption to perception, thinking, emotion and behaviour. Experiencing symptoms of psychosis is often referred to as having a *psychotic episode*.

[30] http://www.nhs.uk/Conditions/Psychosis/Pages/Introduction.aspx
[31] http://www.nhs.uk/Conditions/Psychosis/Pages/Introduction.aspx

336) Psychosis describes a number of experiences, that can include a combination of:

- hearing / seeing things others can't
- unusual changes in behaviour
- feeling 'uneasy'
- racing thoughts
- confused thinking
- false beliefs or delusions
- a feeling of being watched
- frightening or strange ideas
- withdrawal from friends or family
- being suspicious of people
- saying or believing things that don't make sense[32].

337) A psychotic episode can be triggered if a person suddenly stops taking drugs or alcohol after using for a long time in large quantities (known as withdrawal) or after drinking large amounts of alcohol or being high on drugs.

338) Drugs known to trigger psychotic episodes include[33]:

a) *Cocaine*
b) *Amphetamine (speed)*
c) *Methamphetamine (crystal meth)*
d) Mephedrone (MCAT/Miaow/Bounce)
e) *MDMA (ecstasy)*
f) *Cannabis*
g) *LSD (acid)*
h) *Psilocybins (magic mushrooms)*
i) *Ketamine*

[32] http://www.nhs.uk/Services/trusts/Services/Service/DefaultView.aspx?id=197694
[33] http://www.nhs.uk/Conditions/Psychosis/Pages/Causes.aspx

339) Although Adult B disclosed using Mephedrone (Bounce), very little information was documented about his use of Mephedrone by the North Cornwall Mental Health Team. This may be because Adult B stated that he was no longer using and things had improved. It is possible that more in-depth discussion took place during the assessment, however this was not recorded.

340) The notation of Adult B's ulceration of the nose (see 312) above) suggests that his use of this substance may have exceeded one occasion. However some user-forums and leading researchers[34] report that severe nose bleeds, nasal drip ulcerations and nasal pain are common side effects of Mephedrone after insufflation (snorting) and can be experienced within days of using the substance (even for the first time)[35].

341) Other health complaints communicated by Adult B are consistent with Mephedrone use. For example, heart palpitations, fatigue, insomnia, loss of short-term memory and loss of appetite are all common side-effects, however, as with the nose ulcerations, it is difficult to establish from these side effects how long or how frequent Adult B was taking the drug.

342) It was never established whether first time use, or prolonged use of Mephedrone caused Adult B's 'strange behaviour' (described by C4a during the GP consultation) in 2010 but by the time he attended the Mental Health Assessment, he claimed to have stopped taking the drug. Despite this the Panel decided to share information pertaining to Adult B's mental health assessment and previous Mephedrone use with Devon and Cornwall Police for disclosure purposes on the basis that Adult B claimed, in his defence, that he could not remember the assault of his Grandfather due to drug and alcohol consumption (toxicology reports found traces of alcohol, ecstasy and cannabis in his blood on the night that he attacked Adult A). As Adult B mentioned 'memory loss 'within

[34] Erik Gunderson, MD Assistant Professor, Department of Psychiatry and Neurobehavioral Sciences and Department of Medicine Director, Clinical Pharmacological Research Unit, University of Virginia April 14, 2011
[35] https://answers.yahoo.com/question/index?qid=20101019033458AAzUVgF http://www.drugs-forum.com/forum/showthread.php?t=123259 http://www.legalhighsforum.com/showthread.php?130-Mephedrone-Health-Thread/page4

his mental health assessment in 2010[36] the Panel believed that this information was relevant to the defence and prosecution teams.

343) However Adult B's account of memory loss and his guilty plea of manslaughter were not accepted by the prosecution and the jury was asked to decide whether Adult B intended to cause serious harm to Adult A when he entered his flat on the 17th April 2012. This, the prosecution claimed, would be the difference between murder and manslaughter.

344) In considering whether Adult B *intended* to cause serious harm, the jury examined the behaviour and actions of Adult B leading up to the attack, including his use of drugs and alcohol and previous exchanges with drug dealers.

345) The jurors assessed whether his drug use could have caused an abnormality of the mind which would have impaired Adult B's ability to exercise self-control, form rational thought or understand his actions. If this was a possibility, the jurors could have convicted Adult B of manslaughter on the grounds of diminished responsibility in accordance with Section 52 of the Coroners and Justice Act 2009 (England and Wales).

346) However, after careful deliberation of all of the evidence, the Jury unanimously found Adult B guilty of the murder of Adult A. They did not accept that Adult B committed the homicide due to diminished responsibility or that he simply 'pushed over Adult A's mobility trolley', not intending to cause harm. The jury believed that Adult B was of sound mind and discretion and unlawfully killed (i.e. not self-defence or other justified killing) Adult A with the intent to kill or cause grievous bodily harm (GBH). They agreed with the prosecution that the force needed to break Adult A's neck was too "severe" to be accidental.

347) In summarising the case, the Judge agreed with the jury that Adult B '*knew well what had happened and intended what he did'.*

348) It would appear from the outcome of the criminal justice trial that the possible psychotic experience in 2010 had no bearing on the homicide of Adult A in 2012.

[36] 'Cannot remember talking to the paper bag and does not know why he would not remember'

Relationships and Risk to Others

349) The mental health assessment undertaken by North Cornwall Mental Health Team includes the first reference to Adult B's relationship with his Grandfather Adult A. It states *'(Adult B) had a close relationship with his Grandfather until recently when he was accused of stealing money, this affected their relationship'.* This was new information to the Panel that was not mentioned within the family meetings (with F3 and F4) or the initial criminal investigation.

350) It could be that this was a conflict that remained a private family matter between Adult A and Adult B. It does highlight that the relationship had been strained in 2010, some two years prior to the homicide. As Adult B continued to visit his Grandfather regularly between 2010 and 2012, it would be reasonable to assume that this matter was resolved between them. However the accusation of stealing could provide some insight as to why Adult A said to C3 two weeks prior to the homicide *"(Adult B) was in trouble* ***again****"* (see 179) above). The term *'again'* would suggest that either Adult A was aware of Adult B's discord with drug dealers leading up to the homicide or he knew of a previous incident when Adult B was *'in trouble'* over money.

351) There was no information at the time of the assessment to indicate that the deterioration of the relationship with Adult A in 2010 was outside of 'usual' family conflicts. This information would not have led the CPN to assess Adult B as a risk to Adult A.

352) Consideration after the assessment could have been given to whether Adult A was a vulnerable adult and whether the issue of Adult B being accused of stealing from him was an adult safeguarding issue. This would have been difficult to assess as these were allegations and a self-disclosure from Adult B, not a concern about vulnerability or adult abuse being raised by Adult A or another agency. Nevertheless there is no recording of the CPN or Student Nurse enquiring about the age of Adult A or detailing other health and wellbeing information i.e. disabilities or receipt of community care services. Although the deterioration of a family relationship was not a primary factor for the referral, it would have been good practice for the CPN to consider adult safeguarding and

record basic information about Adult A to assist with further discussions or assessments.

353) The Review Panel does recognise that it is difficult to explore areas of potential concern when rapport and trust have not yet been established. 'Pushing' someone to share sensitive information can have the effect of 'shutting a person down'; leaving them feeling reluctant to disclose further information. Adult B could have interpreted further questioning about Adult A as a potential criticism of his disclosure or an intimation of wrong doing. The Review Panel acknowledge that professional judgement must be exercised at the time of the assessment however this cannot be to the detriment of adult safeguarding obligations.

Engagement and Communication

354) Unless it is necessary to detain an individual for treatment under mental health legislation or use powers for compulsory treatment[37], individuals may choose not to accept treatment under the NHS Patient Choice Agenda[38]. Adult B exercised his right not to engage with the Early Intervention Service but the service remained open to him due to his age (17) and contact and monitoring of the situation was made via his parents (C4a).

355) There is a balance between engagement, encouragement and service-users feeling as though services are 'harassing' them. The letter sent to Adult B regarding his discharge from the Early Intervention Service was respectful and sensitive to the non-attendance, acknowledging his right not to attend and 'leaving the door' open for support should his circumstances change.

356) The Review Panel enquired whether the discharge letter sent to Adult B (copying in his GP) was a standard letter e.g. '*As a result of your non-attendance at arranged appointments I am presuming that things are now working out well*

[37] as set out in its Mental Health Bill 2006
[38] http://www.mentalhealthy.co.uk/news/610-mental-health-now-included-in-%E2%80%98nhs-patient-choice%E2%80%99.html

for you'. The Review Panel was informed that the letter sent to Adult B on 11th June 2010 was not a specific standard template used by a range of mental health services.

357) In discussion with Clinical Services Managers, the IMR Author established that there were no standard templates for non- attendance. Each service had its own basic outline which was tailored to meet the circumstances of the referral and non-attendance. The Clinical Services Manager advised that it would not be good practice to have one standard letter as each case should be dealt with on its own merit.

358) The wording *'presuming all is well'* used in the discharge letter from the Early Intervention Service was discussed by the Review Panel. The IMR Author perceived the practice of writing bespoke discharge letters following non-attendance as good practice but confirmed that work was undertaken in September 2012 to review non-attendance and discharge processes to set out guidelines on how mental health services should respond (including appropriate wording). Guidance has since been drawn up and this is now available to all staff within Cornwall Foundation Trust.

Conclusions

359) The assessment by the North Cornwall Mental Health Team was of an acceptable standard at the time. It was a holistic assessment carried out by mental health staff with a recommendation to refer Adult B to the Early Intervention Team as a matter of precaution due to his young age.

360) The care pathways were clear. The GP made a referral to the Cornwall Mental Health Trust. A mental health assessment was completed within 24 hours. An internal referral was made to the Early Intervention Service on the same day of the assessment. The referral was acted upon and correspondence was sent out 48hrs after the assessment to Adult B, his family and GP. An appointment for the Early Intervention Service was sent out within 7 days. This was good

practice.

361) The outcome of the mental health assessment was communicated effectively and appropriately and documentation was of a good standard. Paper records included dates, times, signatures, designations and printed surnames as is required of registered nursing staff.

362) The initial assessment did not indicate any mental illness or raise significant concerns for the safety of Adult B or his risk to others. Information from the assessment was not uncommon of many teenagers 'trying out' illicit substances or experimenting with peers. Adult B communicated 'typical family/teenage dynamics' but acknowledged that he had been affected after taking illicit substances. The CPN referred to the Early Intervention Service on the same day as a precautionary measure due to his age to consider an emerging first psychotic presentation. This was a proactive approach and an appropriate outcome.

363) In accordance with the NHS Patient Choice Agenda, Adult B exercised his choice not to engage with the Early Intervention Service (EIS). His right to choice was balanced with appropriate attempts by the EIS to offer repeat appointments. Communication with C4a extended to letters and telephone calls. Every effort was made to support C4a and Adult B to attend the Early Intervention Service. No opportunities were missed to engage Adult B. Without his engagement it was not possible to carry out a further assessment.

364) The Early Intervention Service (EIS) multi-disciplinary clinical team were responsible for the decision to close the case at the multi-disciplinary team meeting during the week of the 1st June 2010. The EIS team consists of a Consultant Psychiatrist, Team Manager (a Registered Mental Health Nurse), a Psychologist, Registered Mental Health Nurses, an Occupational Therapist, Support Workers and Administration staff. Ultimately the responsibility for the decision to close the case was held by the Consultant Psychiatrist and the Team Manager.

365) In 2010 this was acceptable and standard practice and would be acceptable expected practice today.

366) The appropriate service existed to meet Adult B's needs – the referral criteria for the Community Mental Health Team included under 18 year olds which was not usual practice in other mental health services in the UK at the time (most Community Mental Health Teams work with adults 18 years and above). This demonstrated good, inclusive practice.

367) Since 2010 services have developed in Cornwall Foundation Trust with young people under 18 years old now able to access the Early Intervention Service within Child and Adolescent Mental Health Services (CAMHS) for first presentation psychosis.

368) Although it would have been good practice for the Mental Health staff at the assessment to gather more information about Adult A in relation to adult safeguarding and financial abuse, at no time during the assessment or in follow up contact with Adult B's mother (C4a) was there an indication of an ongoing safeguarding adult concern for Adult A, or an escalating anxiety for the welfare of Adult B. The disclosures made by Adult B were discussed in the context of 'usual family life / relationships' seen through the eyes of a teenager. There was no indication that Adult B posed a risk to himself or others, including Adult A.

369) No information held by Cornwall Foundation Trust would lead to the belief that this significant and tragic event would occur. The jury concluded that Adult B was of sound mind at the time of the homicide.

CORNWALL & ISLES OF SCILLY PRIMARY CARE TRUST (CIOSPCT) IMR[39]

370) The IMR Author for the Primary Care Trust (PCT) is a General Practitioner and a Senior Medical Advisor to Cornwall and Isles of Scilly PCT.

371) On behalf of the PCT, the IMR Author undertook a comprehensive review of the medical records of Adult A from 1st January 2011 to the 17th April 2012 and Adult B's medical records from 1st January 1992 to 17th April 2012.

372) As explained within the scope of the review (paragraph 13) above) the Independent Chair later changed the scope of the review for Adult B from the 1st January 2010 to the 17th April 2012.

373) The Panel therefore only analysed Cornwall and Isles of Scilly PCT's contact with Adult B within the amended scope of the review.

374) The IMR Author conducted 11 interviews with medical staff of which 9 were face-to-face interviews and 2 were telephone interviews.

Summary of Involvement

375) Adult A and Adult B were registered with the same medical practice. They also shared the same General Practitioner, Dr A.

Adult A

376) During the scope of the review, Adult A received 10 home visits and 2 telephone consultations linked to his advanced age and physical frailty. The Community nurses also visited Adult A at home for routine catheter changes which were scheduled every six weeks.

[39] CIOSPCT was abolished on 31 March 2013 as a result of the Health and Social Care Act 2012. The responsible authority for future GP IMRs is NHS England Devon and Cornwall Area Team.

377) Community nurses, family members, carers and the residential warden made regular telephone contact with the medical practice on Adult A's behalf.

378) From the review of the medical records of Adult A, and the interview with Dr (REDACTED) there were no indications to suggest that Adult A was suffering from, or was at risk of abuse. Nor were specific welfare concerns raised by the community nurses employed by Peninsula Community Health who regularly visited Adult A and who had frequent contact with staff at (REDACTED) Medical Centre.

Adult B

379) The medical records held at (REDACTED) Medical Centre do not contain information which indicates that Adult B was considered to be a risk to others. There was neither a record of escalating behaviour problems in Adult B's medical notes nor a history of behavioural issues or concerns stemming from childhood or adolescence. He was not the subject of any child protection plans or care orders during the scope of the review.

380) The first contact with (REDACTED) Medical Centre within the scope of the review was on the 2nd March 2010 when the mother of Adult B raised worries about his behaviour during a consultation with Dr P. Dr P recorded concerns that Adult B may have been suffering from a psychotic episode, possibly related to the misuse of an illicit substance.

381) The details recorded in Adult B's medical notes include *'paranoid ideas, hallucinations, insomnia, aggressive behaviour, hiding knives, reported substance misuse (Bounce – Mephedrone)'.*

382) Dr P. made a verbal telephone referral to North Cornwall Community Mental Health Services for an assessment which took place the following day. He was assessed by Community Psychiatric Nurse (CPN) whose letter of the 4th March 2010 details her intention to refer Adult B to the Early Intervention Service, (REDACTED) House, (REDACTED) Hospital who provide specialist care in first presentation psychosis.

383) Adult B did not attend his appointments with the Early Intervention Service who wrote to the practice on 8th June 2010 stating that no further follow-up was planned. The letter read: *'we are treating your non-contact as an indication that things are currently well and therefore do not plan any further contact at this time.'*

384) There is no further mention of mental health issues in Adult B's medical notes.

Analysis of contact with Cornwall & Isles of Scilly Primary Care Trust

385) The IMR Author on behalf of the Cornwall and Isles of Scilly Primary Care Trust focused predominantly on Adult B's contact with (REDACTED) Medical Centre and the verbal referral made to North Cornwall Community Mental Health Team in March 2010.

386) The IMR Author identified three keys areas of concern relating to the processing of information within (REDACTED) Medical Centre and the follow-up procedure for patients who do not engage with specialist Mental Health Services.

387) These issues are raised and addressed individually below;

Concern 1: Policy for the follow-up of young patients who do not engage with Mental Health Services

388) On the basis of Adult B's age (17 years), the IMR Author considered it best practice for a Clinician from the Medical Centre to contact Adult B upon receipt of the discharge letter from the Early Intervention Service to enquire about his wellbeing.

389) The Panel recognise that this would be good practice, however such practice would be reliant upon;

a) The Medical Centre's process for incoming information to the surgery and how this is brought to the attention of the referring GP;

b) The referring GP having their own mechanism in place to review outcomes or track referrals in the absence of a formal incoming correspondence process;
c) a clinical standard for Mental Health correspondence that is seen by the referring GP and not simply filed/uploaded on the patient's record;
d) The above clinical standard requiring GPs to contact the patient on receipt of a 'did not attend' or 'no further follow-up' letter to establish the person's welfare, and if possible, reasons for non-attendance;
e) The Clinician's having the time to provide this level of follow-up.

390) Adult B's registered GP (Dr A) expressed the view that non-attendance at appointments occurs commonly in patients who suffer from mental health problems and that the practice regularly receives similar discharge letters[40]. He stated that it is not routine practice to follow up such letters due to the additional volume of work which would add to the existing heavy workload in General Practice.

391) The Medical Director for NHS England (Devon and Cornwall Area Team) supported Dr A's view, adding that there was no specific guidance relating to young people that would require a GP to act any differently to an adult patient, other than the intercollegiate safeguarding guidance and "Gillick competency", which is not a guideline but a legal precedent. In his view, it would be rare for a GP to disagree with a Consultant or specialist opinion unless there was evidence to suggest that Adult B's discharge was unreasonable or unsafe. In this case it is assumed that the registered GP accepted the advice of the specialist team and their judgement that Adult B's situation had stabilised.

392) The Panel has since been informed that (REDACTED) Medical Centre has introduced a local, monthly meeting between the Practice GPs, Counsellors, a local Community Psychiatric Nurse (CPN) and a Consultant Psychiatrist to enhance communication between the Practice and the local

[40] Generally patients miss about 20% of scheduled appointments for mental health treatment, almost twice the rate of other medical specialties (http://apt.rcpsych.org/content/13/6/423.full)

Mental Health Team. All mental health referrals are now discussed at these meetings and Adult B's case would now be discussed in a collaborative team setting. The Panel considers this to be good practice and an appropriate response to non-attendance for adults and young people.

Concern 2: Communication of information between Secondary and Primary Care

393) The IMR Author raised an issue relating to written communication between Secondary Care Services and General Practitioners resulting in correspondence being addressed to the **registered** GP and not the **referring** GP.

394) In this instance, the GP who referred Adult B to the North Cornwall Mental Health Team was not Adult B's registered GP. On the 2nd March 2010, Adult B saw another GP from (REDACTED) Medical Centre – Dr P.

395) Due to Dr P's initial referral to North Cornwall Community Mental Health Team being a **verbal** referral, all subsequent correspondence was sent to the surgery's registered GP (Dr A) as recorded within Cornwall Foundation Trust's IT directory. This is standard practice unless there was a specific request made at the point of the referral to include or share correspondence with another Clinician.

396) Nevertheless, Dr P expressed her opinion during an interview with the IMR Author that Adult B's non-attendance at clinic appointments could not safely be assumed to indicate that he was well, and had she received a copy of this letter she would have wished to review Adult B's case to confirm that he was indeed well.

397) Whilst this would have been good practice and above and beyond what would be expected of her as a GP, the Panel learnt that the Administrative Personnel at (REDACTED) Medical Centre regularly encounter problems

processing letters received from secondary care. Due to the way in which secondary care letters are addressed to the registered GP, the surgery has found it difficult to adopt an effective and consistent system for processing and signposting correspondence (leading to concern 3 below);

Concern 3: Processing of information within (Redacted) Medical Centre

398) The Panel was informed that the general dissemination of correspondence within (Redacted) Medical Centre is managed by Administrative Staff who scan the letters into the computer (Evolution System) and direct them to the workflow of whichever GP is named as the addressee. If this GP is absent the letter is signposted to any GP who is available on the day. The Evolution System enables correspondence to be viewed by multiple clinicians; however at present, correspondence is directed to one GP, and is forwarded to other clinicians at the discretion of the first GP.

399) In this case Dr A, the registered GP received the letter from the Early Intervention Service detailing non-attendance. The referring GP, Dr P was not named on the letter or informed of the outcome. In order to identify other clinicians involved in the care of Adult B, Dr A would have needed to check back through the computer record.

400) The Panel was told that it was not feasible for the registered GP to check the medical records to ascertain which GP made the original referral due to the time and resources available to clinicians within Primary Care. Nor did he consider it proportionate given the outcome of the assessment (i.e. Mental Health Staff did not assess that Adult B was a risk to himself or others and this was substantiated by C4a).

401) It is acknowledged that General Practice is undergoing a transformation in the way in which care is delivered. Practice Teams now consist of complex combinations of GP partners, salaried employed GPs, Nurse Practitioners;

Clinicians working part-time and full-time alongside transient Locum Staff which can create a challenge for the internal processing of important written communication.

402) To respond to this transformation, a protocol should be established between primary and secondary care, to identify which primary care clinicians should be named in all correspondence about a patient subsequent to a referral being made.

Conclusions

Adult A

403) The care provided to Adult A appears to have been appropriate for, and sensitive to, his specific requirements in terms of his advanced age and physical frailty. There was good communication between Medical Practice and the Community Nurses, family members, Carers and the Residential Warden.

404) There is no information from medical records or staff interviews to suggest that Adult A was at risk of harm. The information available indicates that he lived in sheltered, secure accommodation and he was well-supported by family and professional Carers.

Adult B

405) From the review of Adult B's medical records and from interviews with staff at (REDACTED) Medical Centre, it is not possible to draw conclusions about the mental health of Adult B in the months preceding the homicide. The medical records do not detail any recurrence of the reported paranoid ideas, hallucinations and behavioural disturbances which were reported in March 2010 and there is no report of any violence or escalating behaviour, or any family concerns.

HARTLEY HOME CARE - Individual Management Review

406) The IMR Author has been employed by Hartley Home Care since 2012 and has over 20 years' experience managing Human Resources Departments. He carried out a review of Adult A's care plan for the purposes of this review.

Summary of Involvement

407) Hartley Home Care was commissioned on the 25th August 2011 to provide domiciliary care for Adult A. The care plan commenced on the 30th August 2011 and comprised of four visits per day.

408) The visits were scheduled in the morning, at lunch time, at tea time and at bedtime. The purpose of the care visits were as follows;

- MORNING: 45 minutes – to assist with getting out of bed, washing, dressing, preparing breakfast.

- LUNCH TIME: 30 minutes - to prepare a hot meal and drink and wash dishes.

- TEA TIME: 15 minutes - to prepare snack and a hot drink.

- BED TIME: 30 minutes - to assist with going to bed and preparing a hot drink.

409) From the 24th September 2011 the care plan was modified and the tea-time visits were increased to 30 minutes.

410) The Care Plan from Cornwall Council contained a section entitled "Useful information for those providing care" It was completed by Adult A and reads;

"I'm (Adult A); I am 91 years of age and live alone at (Redacted) Close which is sheltered accommodation in (Redacted). I have four sons living locally and my family helps me at home.

I require support to wash, dress and undress daily also full support around meals, snacks and hot drinks. My daughter in laws (Redacted and C3a) shop, undertake laundry and clean my house for me. (C3) reorders and collects my medications and helps me with paperwork and bills.

My Support Worker pops in 3 times a week and a Community Nurse visits every three months to change my catheter.

I keep myself safe by always wearing my lifeline, walking with my trolley and accepting assistance from carers. My budget is £ (Redacted) per week and I wish for Adult Care and Support to manage this on my behalf as I don't want the worry of this.

I am happy with the level of care from Hartley Home Care and wish for the four visits to continue.

My family, my home and carers from Hartley Home Care are important to me".

411) On the 15th December 2011 a routine Quality Control and Care Procedures Check was carried out. Adult A recorded that he was very pleased with his care.

412) Carers continued to visit Adult A four times per day until the date of the assault.

413) S28 was a regular Carer to Adult A since 2011. S28 said that she always found Adult A to be chatty with never a bad word to say about anyone. He was mentally sharp and fairly mobile using his trolley to get around. All of his family would visit and Adult A said he was closest to Adult B and C4b. C3 and his wife would also help with the shopping and errands. S28 said that Adult A talked a lot about his family, amongst other subjects, and seemed very close with them. She

thought that he was very proud of his Grandson, Adult B, who was working as a (*redacted*).

414) S28 would usually enter Adult A's accommodation through the ground floor door via intercom or the first floor door to which she had a code for the key safe. His door would be generally unlocked by the first carer in the morning and would be secured by the last carer at night.

415) The last carer (S52) to ever visit Adult A on the 16th April 2012 had attended his sheltered accommodation three times during the day and completed a care log for each visit. Her last visit was at 21:30 hours and she reported no problems. S52 left Adult A alert and mobile before locking the door and placing the key in the key safe as usual.

416) There was no indication that Adult A was at risk during any time of Hartley Home Care's involvement. Members of his family were often present when the carers called and they recorded that his family were generally very supportive of him.

Analysis of Contact

417) Hartley Home Care had been providing care to Adult A for 230 days prior to the homicide. In this time, Adult A did not give the impression that he was at risk from any of his family members. He spoke highly of each of them and they appeared friendly and supportive of Adult A in the presence of Carers.

418) Carers visited Adult A approximately 920 times over the course of the commissioned care plan, which would have provided ample opportunity to identify signs and symptoms of abuse.

419) Although Hartley Home Care did not have a standalone policy or training programme for Domestic Abuse at the time, all of its Care Assistants were trained to recognise signs of elder abuse through a one-day induction course; which included a DVD of different forms of elder abuse, likely perpetrators and how to report abuse.

420) All Care Assistants must complete the one-day induction course before they are allowed to work unsupervised with clients.

421) Whether a one-day course is sufficient to equip Care Assistants with the confidence and competence to identify and report elder abuse is somewhat unknown as the Panel is not privy to the number of adult safeguarding referrals made by Hartley Home Care. However staff did not receive specific domestic abuse training as part of this induction, therefore it is unlikely that they are aware of power and control dynamics of domestic abuse or how to identify or assess high risk relationships. They do not use the DASH Risk Model.

422) The entry system to Adult A's sheltered accommodation was managed safely by the Care Assistants from Hartley Home Care. The door was locked on the 16th April by the last Carer and the key was returned to the key safe. It is known that Adult B used his father's keys to enter the property in the early hours of the 17th April 2012, demonstrating that the key safe was not compromised during the incident.

Conclusions

423) From the information Adult A provided to Hartley Home Care, the routine Quality Control and Care Procedures Check on the 15th December 2011 and the testimony of Care Assistants involved in Adult A's Care, there does not appear to be any reason to believe that Adult A was at risk of abuse, or that Adult B posed a risk to his Grandfather.

424) There was no way that Hartley Home Care could have anticipated the events of the 17th April 2012.

425) Nevertheless, domestic abuse impacts on victims of all ages and can often be differentiated from elder abuse by the presence of a power and control dynamic. To ensure that the Care Assistants at Hartley Home Care are competent to identify emotional, financial, physical, sexual and psychological abuse, the Panel recommends that specific training for domestic abuse is incorporated into the induction training (including information on local domestic abuse and MARAC pathways).

LIFELINE SERVICES – Individual Management Review

About Lifeline

426) Lifeline is a telecare service throughout Cornwall which provides clients with a way of calling for help 24 hours a day, 365 days a year. Clients are provided with a static device or a pendant that can be worn around the neck. Once the red button is pressed it immediately connects to a 24-hour Telecare Response Centre.

427) Operators at the Telecare Response Centre take action on behalf of clients to provide the help or assistance they require. Initially all alarm calls are regarded as emergencies. Operators will attempt to check the needs of the client and respond accordingly – which may include contacting a friend or relative, the police or the ambulance service.

428) Lifeline holds the telephone numbers of a minimum of two points of contact (e.g. Next of kin or friend) per client, should assistance be required.

429) Operators may call the contacts, in order of preference, at any time of the day or night to assist with an emergency. The contacts are expected to have a key to the property, or know where a key is sited, or know the code number to the key safe (if applicable). If for any reason, such as a holiday, or illness, the contacts are not able to help for a period of time, Lifeline will make a note of the temporary arrangements.

430) Lifeline attempt to respond promptly to all calls within 30 seconds.

431) Cornwall Lifeline handles some 250,000 calls through the Lifeline system each year and is accredited with the Telecare Services Association (TSA). The TSA are recognised as the lead body for setting industry standards and monitoring performance against these. Cornwall Lifeline is independently audited on an annual basis to retain this accreditation.

Methodology used to undertake IMR

432) The IMR Author for Lifeline Services has been employed since 2010. A detailed examination of the time line of events for all calls regarding Cornwall Lifelines contact with Adult A was undertaken from 10th May 2010 to the 17th April 2012.

433) All contemporaneous notes made by operators in dealing with Adult A were checked and compared with voice recordings and a copy of the calls on the 17th April 2012 were supplied to Devon & Cornwall Police as part of the criminal investigation.

Summary of Involvement

434) During the period 10th May 2010 and 17th April 2012 Cornwall Lifeline received eight calls from Adult A, of which;

a) one (1) was a mistake

b) two (2) were due to a fault with the system

c) one (1) was due to a low battery

d) one (1) was Hartley Home Care – Carer did not know password for entry

e) one (1) was a call from Adult A to say that he had run out of laundry tokens

435) Of the eight calls, only two were a request for emergency assistance;

a) 21st July 2010 – Adult A had slipped in the bathroom and couldn't get up

b) 17th April 2012 – 01:44 hours. No response was received from Adult A – Operator could only hear the TV and a bird tweeting.

436) Following the call on the 17th April, the Operator tried to contact Adult A via his landline but received no response. Contact 1 (C3) was telephoned but there was no response (C3 was on holiday). Contact 2 (C1) was telephoned and he agreed to make contact with Adult A.

437) A further call was received at 02:39 hours on the 17th April. The Operator called Adult A's landline and spoke to a Police Officer who was at the property and had accidentally pulled the intercom cord. The Police Officer confirmed that Adult A had had a fall and that an ambulance crew was on site.

438) No further information was received for Adult A other than a notification from Devon and Cornwall Police to confirm Adult A's death and to request evidence for the subsequent investigation.

Analysis of Contact

439) Cornwall Lifeline and the Operator who handled the calls on the 17th April 2012 responded in accordance with the operating procedures set out in the Cornwall Lifeline Operational Procedures Manual.

440) This included adherence to the procedure for 'no response' calls. A 'no response call' is one where an alarm call is received from the equipment, e.g. via a pendant, but contact cannot be made with the user. As prescribed within the operating procedures, the Operator contacted Adult A by landline before contacting his designated family members.

441) Contact 1 (C3) was not available as he was on holiday at the time. Cornwall Lifeline was not informed by the family of any temporary arrangements, hence the initial call to C3. Having failed to contact C3 the Operator successfully contacted C1 and, in keeping with procedure, confirmed with C1 that he would assume responsibility for undertaking a welfare check.

442) As is best practice, C1 was asked to press the alarm on arrival to confirm that he was with Adult A and no further help was required. Understandably when C1 attended the flat, he found Adult A on the floor and realised he had been assaulted. C1 immediately called the Police.

443) Overall, Cornwall Lifeline's response to Adult A's emergency call on the 17th April was both efficient and effective. The alert was answered within 30 seconds and the family was called within 1 minute. This was in line with standard operating procedures at the time and would be good practice today.

444) Applying the principle of thoroughness, the Panel enquired about specific training for Operators around domestic abuse. They were informed that all Operators receive Adult Safeguarding Training on a 2 year basis. A new e-learning programme developed by the Safeguarding Adults Unit (Cornwall Council) includes content on domestic abuse.

445) The Cornwall Lifeline Management Team state that Operators know how to identify signs of abuse and escalate concerns; however calls from Adult A were not sufficient to raise concerns and no suspicious activity was recorded.

446) The majority of contact with Adult A was as a result of mistakes or system errors, however, the Panel noted that a scheme such as Lifeline could be easily used by vulnerable individuals as a way of alerting professionals to abuse, even if the alerts are later retracted or denied by the client. In this instance the Panel asked if there was a threshold for 'mistake calls' before Operators would raise concerns about a particular address or notify a senior manager. The Panel received the following response;

a) *"Individual usage and reliance varies greatly from client to client and to incorporate this type of usage we do not have any prescriptive thresholds. Each call and client is handled to the individuals needs and operators look at the call histories to see if there has been any unusual or increasing activities or if other operators have added additional notes which may be relevant to the current live call. This allows any individual operator taking any call to raise concerns immediately or at the very earliest opportunity to a member of the Management Team who will investigate further and take any necessary action. If there is immediate urgent assistance needed 999 services will be summoned by the operator and the Management Team informed immediately. This system is tried and tested and Cornwall Lifeline staff can escalate, and have escalated, any concerns to a member of the Management Team. There is a member of the Management Team available 24/7, either in person or on standby. Information supplied by Cornwall Lifeline has been used by the Police to help secure prosecutions where abuse has taken place in the past".*

Conclusions

447) In conclusion, the Cornwall Lifeline Service had no contact with Adult A that could have alerted them to the events of the 17th April. Previous calls received through the emergency alert system did not raise concerns or indicate signs of abuse from any individual (family, professional or otherwise). When emergency calls were received from Adult A, Cornwall Lifeline dealt with them competently and commendably in line with company policy and industry standards set by the Telecare Services Association (TSA).

448) Operators were trained to identify signs of abuse through Adult Safeguarding Training obtained from the Adult Safeguarding Unit at Cornwall Council. The Cornwall Lifeline Management Team ensures all Operators receive refresher training every 2 years. This case highlights the importance of refresher training and the need for professionals to stay abreast of learning in order that a bespoke individual-led approach can remain safe and effective.

CORNWALL HOUSING – Individual Management Review

449) The IMR Author on behalf of Cornwall Housing is a Corporate Member of the Chartered Institute of Housing, with 20 years' experience within the housing sector, seven of which are at a Senior Management level.

Summary of Involvement

450) Adult A was a Council tenant living in a sheltered housing scheme (since 1998). As such he received the Independent Living Service. All persons receiving the Independent Living Service have a Support Plan produced to document their individual needs and identify the support which will be delivered in order for the tenant to retain their independence and well-being. The Independent Living Service delivered a series of regular visits to Adult A and these are listed in the full chronology (see Appendix A)

451) The sheltered housing property offered Adult A some communal services, such as a laundry room, common room and social events which were organised within the scheme. Adult A had his own individual accommodation with a separate entrance. A Supported Housing Officer (Resident) visited Adult A on a regular basis and completed a Support Plan.

452) A Support Plan documents the support needs of each individual tenant and where necessary identifies outcomes to maintain their independence and well-being. In this instance Adult A was known to have been in good health, despite having a stoma and catheter. Adult A was well supported by his wider family who visited regularly to complete laundry, shopping and provide other support.

453) Adult A's Support Plan included 3 visits per week from the Housing Support Officer; which were often general conversations about his wellbeing.

454) A standard part of the completion of the Support Plan was to ask Adult A a series of questions relating to his own personal safety and security. The asking of these questions is a standard process, and not just specific to Adult A, for

assessing the level and type of support an individual tenant may require in supported accommodation.

455) The questions posed to Adult A, together with his answers, are recorded below;

a) Are you happy saying no to strangers or unwanted visitors? **YES**

b) Do you feel safe and secure in your home / neighbourhood? **YES**

c) Do you know who to contact if you suspect you or someone you know are a victim of abuse? **YES**

d) Are you concerned about threats from outside the home? **NO**

e) Are there any potential concerns with resident or visiting children? **NO**

f) Is your home suitable for your needs? **YES**

g) Are there any potential problems with other residents? **NO**

h) Are there any domestic violence issues? **NO**

i) Are there any potential threats of violence from outside the home? **NO**

456) The questions above were originally asked in January 2010 and the Support Plan was again review and updated with Adult A in February 2011 and February 2012. No amendment was made to the responses between 2010 and 2012.

457) The responses to the Safety and Security Check did not raise any concerns with the Supported Housing Officers concerned, and no further support need was identified in respect of Adult A's personal safety and security.

458) The Care Plan logs occasionally recorded that Adult A had company when the visits were taking place; this was often members of Adult A's family or neighbours, but no specific records were made to which relatives were present. Adult B was known as a relative to Adult A and was remembered by the Housing Support Officer as a friendly and pleasant member of Adult A's extended family.

459) On occasions, Adult A was noted to have been sleeping, either in his chair or in bed at the time of calling. During these times, the Housing Support Officer entered the property by obtaining the key from the key safe, using the code.

460) Adult A was visited last on the16th April 2012 when he was recorded to have been sleeping in bed. This was the last registered contact Cornwall Housing had with Adult A.

Analysis of Contact

461) Adult A's sheltered accommodation had a separate entrance with its own key. The key safe was located outside the door and was accessible, by code, to professionals from Hartley Home Care and Cornwall Housing. It has been established that Adult B did not use this facility to access Adult A's flat on the 17th April 2012. He entered the property using a set of keys that belonged to his father. Adult B had taken the keys without permission and unbeknown to any of his family. The Panel is assured that the security to the building was not compromised on the evening of the assault. Cornwall Housing could have not have done anything further to prevent Adult B's unscheduled and untimely visit.

462) The question of whether Cornwall Housing could have improved security through CCTV control is addressed within the Family Section, paragraphs 223) to 225) above.

463) The Support Plan for Adult A listed all vulnerabilities, disabilities, diversity and ethnicity details to ensure that the support provided met his individual needs. In respect of Adult A, although elderly and having suffered from some medical treatments in the past, he did not present with other concerns in respect of his vulnerabilities or disabilities, other than his age.

464) Officers who visited from Cornwall Housing were knowledgeable and trained to identify potential indicators of abuse, but no alerts or concerns were raised, except for the alert raised on the day Adult A had been attacked.

465) The Support Plan process asked specific questions of Adult A to gauge whether there were concerns held by him in respect of his safety and security, but as explained at 455) above these questions were answered negatively to indicate no safeguarding concerns. Adult A was not afraid of any persons nor did he perceive any potential threats of violence from outside the home.

466) The Supported Housing Officer who visited Adult A was trained to look out for indications of abuse within individual responses, home or demeanour, and knew how to support tenants of domestic abuse if necessary through Cornwall Housing's Domestic Violence Policy and Safeguarding Adults Policy.

467) In this instance, there were no concerns for Adult A in respect of domestic abuse or in respect of safeguarding.

Conclusions

468) It would appear from the records Cornwall Housing holds pertaining to Adult A, and through the interview with the Housing Support Officer, that Adult A was supported by a strong, tight knit family who regularly visited and supported him with domestic chores (washing, cleaning, shopping etc.) as well as regular social visits.

469) Adult B was known as a relative to Adult A and was remembered as a friendly and pleasant member of Adult A's extended family. At no point was he considered to be a risk to Adult A. Cornwall Housing had no information relevant to Adult B in respect of domestic abuse, drugs or alcohol misuse. Adult A never raised any concerns about Adult B, either during visits or within the Support Plan Safety and Security Check. The Housing Support Officer was never compelled to seek assistance or support from another professional or agency.

470) The Housing Support Officer could not think of any incident or opportunity which may have led to this homicide being foreseen. Nor could Cornwall Housing identify a policy or process that would have protected Adult A from Adult B.

SECTION FIVE: OVERALL CONCLUSIONS

CONCLUSIONS

471) The content of this section will address the case specific Terms of Reference identified in Section One of this Overview Report (14) to 23) above). To reduce repetition in answering the issues raised some terms of reference have been combined.

472) The overall conclusions summarise the main findings of the Individual Management Reviews. Principle lessons identified from this DHR focus on what, if anything should have been done differently and changes required today to prevent a similar tragedy happening again.

473) The final sections will record all appropriate recommendations about what actions are required by individual agencies to address the findings of this review. The Panel has also made recommendations regarding any implications for national policy arising from the case.

TOR CONCLUSIONS

Were family, friends, key workers or colleagues (including employers) aware of any abusive or concerning behaviour from the perpetrator to the victim (or other persons), prior to the homicide?

474) From the information provided by the family, there were no overt warning signs to indicate that Adult B was a risk to Adult A. The relationship between the Grandfather and Grandson was described by Adult A and independent observers as ‘good’. Adult B would visit weekly and undertake errands for Adult A and this arrangement was not interrupted leading up to the homicide. Although Adult A often gave Adult B money for his tasks, this was a token gift from a grandfather to

his grandson and was neither expected nor forced.

475) At some point leading up to 2010, there was an incident between Adult A and Adult B, which Adult B alluded to within his mental health assessment. Adult B inferred that he had a good relationship with Adult A until he was accused of stealing money from him. This was obviously worthy of a mention and still upsetting for Adult B as of March 2010; however the matter seemed to have resolved itself between 2010 and 2012.

476) If the relationship between Adult A and Adult B did experience difficulties, it appears to have been managed privately between the two relations. Adult A seemed to be aware of some of the issues Adult B was experiencing with drugs and knew that he had encountered some troubles with dealers, but he managed this with discretion only telling C3 that Adult B was *'in trouble again'*.

477) Despite knowing about his Grandson's issues with drugs, Adult A did not communicate to any relative or professional that he felt threatened or unsafe in Adult B's company. To the contrary, Adult A was known to have told C3 on the 14th April 2012 (3 days prior to the assault) that Adult B was *"a good lad"* (see 177) above).

478) Adult B's father (C4) *was* aware of Adult B's escalating behaviour leading up to the homicide and took decisive action on the 11th April 2012 to report his own son to the Police following the theft of his vehicle. If there were any signs at this time to suggest that Adult B would target his grandfather, C4's actions on the 11th of April demonstrate that he would have taken any measure possible to protect his father from his son, including reporting him to the Police.

479) Whilst Adult B's behaviour in the days leading up to the homicide was a cause for concern, there was no way that his family or friends could have linked his arrest on the 11th April 2012 to the assault on Adult A on the 17th April 2012.

480) Was the incident in which Adult A died a 'one off' or was there any warning signs that would indicate that more could have been done to protect him?

481) Very little is known about Adult B's drug-taking between 2010 and 2012, therefore it is difficult for the Panel to adequately assess whether it played a part in the homicide of Adult A, and could be considered as a warning sign.

482) It is possible that Adult B's arrest for aggravated vehicle taking, driving with excess alcohol, driving otherwise than in accordance with a licence and breach of a conditional discharge on the 11th April 2012, (just 5 days prior to the assault on Adult A) was a warning sign that his behaviour was once again deteriorating.

483) It is not known if Adult B consumed Mephedrone or any other illegal substance on the 11th April 2012[41] (or at any time between 2010 and 2012) however Adult B's family suspect that he had transgressed into drug taking and his trip to Plymouth on the 11th April was connected to the purchase and/or supply of drugs.

484) Toxicology tests taken after Adult B's arrest on the 17th April 2012 (for the assault on Adult A) found traces of alcohol, cannabis and ecstasy, consumed either prior to, or after the assault; therefore it can be reliably established that Adult B was using illicit substances around the time of the homicide.

485) The true motive of the crime is only known to Adult B, though the prosecution presented a case that he had planned to visit Adult A on the 17th April 2012 with the intention of obtaining money for alcohol and/or drugs.

486) If alcohol and drugs were a factor in the motive for the assault on Adult A on the 17th April 2012 then it could be argued that his arrest on the 11th April 2012 was a warning sign, however based on the criteria stipulated by the Bail Act of 1976, the Police did not consider Adult B to be a risk to others on the 11th April

[41] The roadside Dräger Drug Test® 5000 System was not available until January 2013

2012.

487) Whilst the Panel acknowledges that the way in which Adult A died was a 'one off' (i.e. there being no previous violence against Adult A) the 'drug and alcohol-fuelled' behaviour that led to Adult A's tragic death was not isolated or atypical of Adult B's past conduct.

488) There is no way of knowing whether a different approach towards Adult B's previous Mephedrone use in 2010 would have changed his decisions or the outcome in 2012. Whilst Adult B's drug taking was a cause for concern, there was no way that his family, friends, or any professional could have predicted his actions on the 17th April 2012.

Were there any barriers experienced by the family/ friends/colleagues in reporting any abuse or concerns in Cornwall or elsewhere?

Did the victim, family, friends, neighbours or co-workers know how to report domestic abuse had they wanted to?

489) This Domestic Homicide Review has identified that Adult A was not a victim of a pattern of incidents of controlling, coercive, threatening behaviour, violence or abuse from Adult B. The assault against Adult A was a *'one-off'* insofar as there was no previous violence; therefore family, friends and neighbours would not have suspected abuse nor been inclined to report it.

490) It is not possible to hypothesise on whether individuals knew how to report abuse at the time (had they wanted to); however a new service was established in February 2014 which promotes a 'single gateway' to all information, support and advice for domestic abuse across Cornwall and the Isles of Scilly. The simplification of the pathway for support, together with a communication campaign to raise awareness of male abuse should make it easier for victims, friends and families to report domestic abuse, if they experience or suspect it.

491) The perceived barriers by C4a in accessing support for Adult B's drug use is described in detail within the family analysis (226) to 239) above). There is no doubt that C4a was disappointed by the lack of information available to help her support her son in 2010. This perceived experience may have had an impact on her decision to access support for Adult B when his behaviour deteriorated again in 2012.

492) Although *'the door was left open'* for Adult B to contact with the Early Intervention Service after 2010, the Chair speculated on whether C4a or Adult B would feel comfortable returning to a service following his initial non-attendance. Even though the offer of further support existed, C4a may have felt unable or unwilling to return for help, which may have resulted in the family coping with Adult B's behaviour in isolation of professional services; therefore creating a barrier to reporting.

Were there any opportunities for Professionals to enquire or raise concerns about domestic abuse in the household?

493) From the information available, there was no indication of historic, or on-going domestic abuse from Adult B towards Adult A. Professionals were alert to the signs and symptoms of abuse and there was ample opportunity for Carers to observe his demeanour, home-life and family interactions, at different times of the day, over many years. No behaviour, action or incident raised concerns around safeguarding leading up to the homicide. When asked specifically about domestic violence (within the Care Plan Safety and Security Check), Adult A answered negatively, to indicate no domestic violence issues (see 455) above).

494) An opportunity did exist for the Community Psychiatric Nurse (CPN) to ask Adult B about Domestic Abuse, however the information received during the assessment would not have automatically alerted staff to enquire about domestic abuse. Staff knowledge of domestic abuse was limited at that time and there was no requirement to specifically ask as routine. In 2012 an outcome from another

serious case review (SCR) resulted in all Cornwall Foundation Trust procuring an e-learning package about Domestic Abuse. This is essential training and all front line staff are required to complete it. The Early Intervention Team is now 100% compliant with this training.

Did the perpetrator have any previous concerning conduct or a history of abusive behaviour and was this known to any agencies?

495) There was evidence of Adult B's history of drug misuse but this did not always translate to a history of violent or abusive behaviour. Indeed, there is a suggestion from family members and from Adult B's own admission, that he was uncomfortable with confrontation and would avoid violence if possible (see 313) above).

496) There are various references to Adult B being a 'good lad' and a 'nice boy' from both sides of the family, and from professionals that met him at Adult A's accommodation; which supports C4s notion that her son's actions on the 17th April 2012 were out of character.

497) However the Panel cannot dismiss the Judge's summing up of the case in which he said *""You lost your temper and in a drunken, drug-fuelled rage you attacked him…You knew well what had happened and you intended what you did. You left him lying, helpless on the floor and you did not call for help..."*

498) Even if Adult B's behaviour on the 17th April 2012 appeared to be *'out of character'*, the jury concluded that the attack on his grandfather was premeditated and unprovoked.

499) That said, there was no previous concerning violent conduct or a history of abusive behaviour known to any agency, professional or family member, therefore there was no way of anticipating the violence Adult B perpetrated

towards Adult A on the 17th April 2012.

Were there opportunities for agency intervention in relation to the perpetrator (e.g. drug/alcohol/mental health issues or child protection arrangements) that were missed?

500) Adult B was referred for a mental health assessment on the 2nd March 2010 for concerns about changes in behaviour, possibly related to the misuse of an illicit substance.

501) The details recorded in Adult B's medical notes and sent to North Cornwall Mental Health Team include; *'paranoid ideas, hallucinations, insomnia, aggressive behaviour, hiding knives, reported substance misuse (Bounce – Mephedrone)'.*

502) A mental health assessment was undertaken on 3rd March 2010 by a Community Psychiatric Nurse and a student at the North Cornwall Mental Health Team (see outcomes 308) to 316) above).

503) The first mental health assessment did not determine any mental illness, nor was there evidence of any ongoing substance misuse. Adult B showed insight and understanding that his use of illicit substances had impacted on his wellbeing and behaviour, and gave examples of this. Adult B denied further use of Mephedrone and reported that his symptoms had improved.

504) As a precaution due to his age, the CMHT staff wanted to be thorough and consider the possibility of an emerging first presentation of a psychotic disorder and made a referral to the Early Intervention Service for this. The Early Intervention Service were unable to engage Adult B in any assessment, however, they did have the opportunity to discuss the referral with Adult B's mother (C4a), who provided confirmation that he was no longer using Mephedrone and that there was an improvement in his wellbeing and mental state.

505) C4a provided assurance that mental health services were not required and that substance misuse was not a problem at that time. The letter of discharge, with the presumption of wellbeing, was copied to the registered GP. At the time of receipt it would be reasonable for the registered GP to take from this discharge letter that the problems from the initial consultation were now resolved.

506) The unanswered issues are that after the death of Adult A it is suspected that substance misuse continued and did impact on behaviour. Neither Mental Health Services nor Primary Care Services were aware. It cannot be stated that if in June 2010 the referring GP had been aware of the non-attendance and HAD contacted Adult B, that information gained at that time would have indicated a problem with substance misuse that required addressing.

Could more be done to raise awareness of services available to victims and perpetrators of domestic violence?

507) The British Crime Survey highlighted the level of under reporting in 2011 with male victims being three times more likely **not to** report domestic abuse than their female counterparts[42]. This would suggest that more could be done to raise awareness of services for male victims of domestic abuse, including male on male family abuse (although domestic abuse was not relevant to this DHR).

508) Following four consecutive Domestic Homicide Reviews involving male victims in Cornwall in 2012/13, the Safer Cornwall Partnership has made a commitment to raise public and professional awareness of male victimisation[43] and seek to dispel gender assumptions that present a barrier to reporting abuse or concerns.

[42] British Crime Survey 2010/11 (page 88) Table 3.16 (page 111) - http://tinyurl.com/7slnnom

[43] Male victims are not a homogenous group and include victims of heterosexual , LGBT and intra- familial abuse

509) In terms of perpetrators, the Panel is aware that the Building Better Relationships (BBR) Programme, delivered initially by the Devon and Cornwall Probation Trust for men convicted of abusive behaviour, transferred over to the Dorset, Devon and Cornwall Community Rehabilitation Company on the 1st June 2014.

510) The Building Better Relationships (BBR) Programme is accessible to men who have been abusive in heterosexual relationships and have been assessed as posing a risk of harm to their partners and children. The programme is delivered via 24 group sessions once or twice per week, plus up to five one-to-one sessions. BBR prioritises the safety of women and children.[44]

511) This means that the only nationally accredited group-work programme for perpetrators of domestic abuse excludes female perpetrators, homosexual perpetrators and male-on-male family perpetrators. Based on the referral criteria Adult B would not have been suitable for this programme.

512) The Building Better Relationships (BBR) Programme only accepts men who have been convicted or cautioned by a court. As less than 24% of domestic violence crime is reported to the police[45] there is a concern that many perpetrators are not referred for treatment because a large proportion of them are not brought to justice for their crimes.

513) To address this gap the Safer Cornwall Partnership commissioned a voluntary perpetrator programme in 2012. The Evolution Programme is a 39 week voluntary attendance programme (in Cornwall) for men or women aged 18 years or over that do not have children on a child protection plan and are not currently involved in the criminal justice system for 'domestic violence' offences.

514) It appears that services exist for perpetrators of domestic abuse in Cornwall however they are only accessible to heterosexual men who have been brought to

[44] http://www.ddccrc.co.uk/what-we-do/programmes/the-building-better-relationships-programme/
[45] Walby and Allen, 2004.

justice or adults (over 18) who acknowledge their behaviour and want to change.

Was there any evidence that Adult A or Adult B were directly or indirectly discriminated against by any agency based on the nine protected characteristics of people who use services under the Equality Act 2010 e.g. age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex and sexual orientation?

515) There is no evidence to suggest that Adult A was discriminated against based on the nine protected characteristics of the Equality Act 2010. All agencies providing care or support to Adult A were sympathetic to his age and disabilities.

516) There is no evidence to suggest that Adult B was directly discriminated against by any agency based on the nine protected characteristics of the Equality Act 2010, however his age (17 years old) at the time of the missing persons report did create some confusion in relation to safeguarding concerns e.g. A 121a Police notification was not completed because of a 'grey area' between the Police and Criminal Evidence Act (PACE) 1984 which defined a child as under 17 (not 18) and HM Government (2013) Working Together to Safeguard Children[46] Guidance that defines a child as anyone who has not yet reached their 18th birthday.

517) Code C of the Police and Criminal Evidence Act (1984) has since been amended to ensure that 17 year old juveniles are no longer treated the same as an adult aged 18 years or over.

Are there any training requirements necessary to ensure a greater knowledge and understanding of domestic abuse processes and / or

[46] HM Government (2013) Working together to safeguard children: A guide to inter-agency working to safeguard and promote the welfare of children

services in the county?

518) The Panel identified the following specific training requirements to address the lessons identified from this review and to help prevent similar tragedies happening again in the future;

519) When Adult B disclosed during his mental health assessment that he had been accused of stealing money from his Grandfather there was no record of the CPN or Student Nurse enquiring about the age of Adult A or detailing other health and wellbeing information which may have identified him as a vulnerable adult i.e. disabilities or receipt of community care services.

520) Although the deterioration of a family relationship was not a primary factor for the referral, it would have been good practice for the CPN to consider whether the issue of Adult B stealing from Adult A was an adult safeguarding issue and to record basic information about Adult A to assist with further discussions or assessments.

521) The Panel understand that since September 2012 an Adult Safeguarding Team has been appointed within Cornwall Foundation Trust to deliver face to face safeguarding training across the service. Current statistics from Adult Care and Support Safeguarding Adults Unit indicates that reporting of adult abuse has increased from Cornwall Foundation Trust in the last 14 months.

522) The Panel was also informed that the Care Assistants responsible for providing daily home care to Adult A each received safeguarding training as part of their induction to the company, however, this did not include specific training around the signs and symptoms of domestic abuse.

523) As domestic abuse impacts on victims of all ages and can often be differentiated from other abuse by the presence of a power and control dynamic,

the Panel would recommend that all Care Assistants at Hartley Home Care are invited to attend multi-agency domestic abuse training[47].

524) Although all agencies that had contact with Adult A or Adult B reported a good level of safeguarding training for their employees, it is vital that professionals keep abreast of changing legislation and best practice guidelines by refreshing knowledge and skills through continued professional development.

[47] Commissioned training is being rolled out between Sept 2014 and Sept 2016.

SECTION SIX: LESSONS IDENTIFIED*[48]

What lessons have been identified from the domestic homicide regarding the way in which local Professionals and organisations worked or work, individually and together to safeguard victims?

525) This section will summarise the key lessons identified from this Domestic Homicide Review (DHR). The number in Column One is the reference to the paragraph(s) within the main body of the report that describes the issue in full. The number in Column Six is a reference to the corresponding recommendation (if applicable) within Section 7.

[48] The Chair has chosen to avoid the term 'lesson learnt'. Lessons cannot be learnt until they are acted upon.

526) **Table: Lessons Identified**

1	2	4	5	6
Para. Ref	**LESSON IDENTIFIED**	**What changes are required to practice, policies and procedures?**	**What needs to change in order to reduce the risk of the incident happening again in the future?**	**Rec. Ref**
Family Analysis 204)	**Bereaved Families must be given better support to challenge Coroner standards.** The delay of 5 months for the release of Adult A's body caused great distress for the family. Although The Ministry of Justice Guide to Coroners and Inquests and Charter for Coroner Services (March 2012) aims to address the imbalance between the rights of	The Charter for Coroner Services, which sets out the benchmark for national standards, needs to be compulsory, not voluntary. Victim Support Homicide Workers should be appointed at the earliest opportunity following a homicide. Police Officers should do more to facilitate the earlier allocation/appointment of a Victim Support Homicide Worker.	Bereaved Families need to be aware of the Ministry of Justice Guidance for Coroners and be supported to challenge any unnecessary delay in the release of the body of a loved one. The Ministry of Justice need to make national standards for Coroner Services compulsory. A regular audit of performance against national standards should be undertaken by the Ministry of Justice, with Coroners held to account for consistent breach of standards. Victim Support Homicide Workers should be	**Rec 1** **Rec 2**

	the perpetrator (who has the right to request a second post mortem) and the needs of the bereaved family, there does not appear to be a transparent form of redress or a mechanism to challenge the coroner when standards are not upheld.	Victim Support Homicide Worker's should be aware of, and keep abreast of, Government legislation, guidance and protocol to support families through the coroner and criminal justice process, and assist bereaved families to challenge (legally, if required) practice when standards are not upheld.	appointed sooner and have the authority to support bereaved families to challenge Coroner standards.	
Family Analysis 189)	**The Criminal Justice Process should be more sensitive to the dynamics of Family Domestic Abuse.** The Criminal Justice System was not accommodating of such a complex and sensitive family dynamic whereby the victims' son was also the perpetrators father. The perpetrator's family felt punished by the criminal justice system and specifically by the court process, even though they did not commit or condone the	The Specialist Domestic Violence Courts, Magistrates and Crown Courts should have a protocol for the sensitive management of family domestic abuse cases where it is known that family members are first relatives of both the victim and perpetrator.	Family Domestic Violence needs to be treated with sensitivity as it is likely that family members will be related to both the victim and perpetrator. Court Staff should consider how to allocate waiting rooms or safe areas for family members at Court.	**Rec 5**

	crime.			
Family Analysis 206) to 214)	**Bereaved family members must be better supported in the aftermath of a homicide.** The Health Impact on the family was not considered leading up to, during, or after the trial. No counselling was offered. No welfare check was made. The new Code of Practice for Victims of Crime introduced by The Ministry of Justice in October 2013 sets out minimum standards of services to be provided to victims of criminal conduct by criminal justice organisations in England and Wales; which includes facilitating pre-trial therapy for any child/young person, or adult that fall into the three priority areas – however Police (and other service	The local protocol pertaining to the new Code of Practice for Victims of Crime for referring victims of crimes who fall into the three priority areas should be more than just a referral or signposting option e.g. telephone number for a helpline or charity. A commissioned or agreed non-commissioned pathway for therapy should exist for victims and the take-up of such services should be monitored by the Safer Cornwall Partnership. A protocol should exist for referrals of victims requiring Pre-Trial Therapy who are progressing through an active criminal justice investigation. The Police and Crown Prosecution Service should be made aware of such therapy and the Counsellor or Therapist should be qualified and experienced to provide pre-trial support.	Given the very high proportion of families experiencing ill health, and the high risk of traumatic grief developing into Post Traumatic Stress Disorder (PTSD), families bereaved by homicide should be offered the opportunity to access trauma-related therapy, bereavement counselling or other intervention, as required. The Code of Practice for Victims of Crime should be more specific about the referral route for pre-trial therapy for victims of the three priority areas. In future, it would be useful to see suggested referral pathways e.g. a referral route to local IAPT Services (Improving Access to Psychological Therapies).	**Rec 3** **Rec 4**

	providers) are obliged to refer a victim for therapy (if required or requested) but have no jurisdiction over whether those services (especially those provided by specialist voluntary organisations) accept the referral or offer treatment.			
Family Analysis 193) to 198)	**It would be good practice for General Practitioners to source information online during the consultation and to ensure that patients (or concerned relatives) understand the purpose of any referrals and possible outcomes.** The family of Adult B did not feel that they received information or support on the illicit substance Mephedrone when they sought help from the GP for Adult B's drug use and possible psychosis.	GPs need to explain the process for addressing coexisting issues when patients or families seek help for mental illness and drug/alcohol concerns. GPs throughout Cornwall and the Isles of Scilly should have information leaflets or website addresses at hand to offer patients and families who require information or support on illicit substances. The Cornwall Drug and Alcohol Action Team (DAAT) should make sure all website information and information available to GPs is up to date and easily	GPs throughout Cornwall and the Isles of Scilly should be given the opportunity to learn lessons from this review, and understand the perceptions of the family members who felt let down by the information they received.	**Rec 6**

	The GP did not explain the decision making process for only referring Adult B to North Cornwall Mental Health Team. The family interpreted this as a 'downgrading of concern' for his drug use and left them none the wiser on the dangers of Mephedrone.	accessible.		
Cornwall and Isles of Scilly Primary Care Trust IMR 393) to 397)	**The current system of written communication between secondary care and primary care services does not guarantee that the referring GP is notified of the outcome of an assessment or the patients' non-attendance.** All correspondence from Cornwall Foundation Trust Mental Health Services was addressed to the registered GP, not the referring GP.	A protocol should be established for written correspondence between secondary and primary care services to identify which primary care clinicians should be named in all correspondence about a patient subsequent to a referral being made.	The protocol for written correspondence between secondary and primary care services should include a mechanism or opportunity for the referring agent to acknowledge safe receipt. This will ensure that all professionals involved with a patients' care have written documentation of who is responsible for follow-up care and safeguarding checks (if applicable).	**Rec. 7**

	The referring GP was never informed of Adult B's non-attendance at the Early Intervention Service.			
Hartley Home Care IMR 425)	**Adult Safeguarding Training is not a guarantee that Professionals have received specific Domestic Abuse Training.** Care Assistants, Lifeline Operators and Housing Officers received safeguarding training and knew how to escalate concerns or raise a safeguarding alert. They did not necessarily know how to identify high risk domestic abuse, understand the power and control dynamic or know how to refer for a DASH Risk Assessment or MARAC	A multi-agency domestic abuse programme should be commissioned to increase the number of professionals who are confident and competent to identify, assess and manage high risk domestic abuse, stalking and harassment and honour based violence. Domestic Abuse Training should be made available to Cornwall Housing, Lifeline Services and Hartley Home Care to ensure that clients of these services benefit from the domestic abuse pathway in addition to adult safeguarding procedures e.g. IDVA support.	Adult Safeguarding Training should include information on high risk factors, DASH and MARAC as a minimum (if specific domestic abuse training is not available). The government should champion national minimum occupational standards of domestic abuse/DASH training for identified professions working with at risk groups.	**Rec 8**

If a similar case presented today, could we expect a different outcome?

527) At the heart of this homicide is the aggravating and devastating consequence of drug and alcohol abuse. Adult B's initial drug use may have been voluntary but eventually he sought out drugs regardless of the negative consequences to himself and his loved ones. He took desperate measures to obtain drugs, including stealing, risking arrest and putting himself and others in harm's way.

528) In its simplest form, this case highlights the crime triangle theory which states that in order for a crime to occur three things must be present: **desire**, **opportunity**, and **ability**. Adult B possessed the drive and motivation to commit the crime. He needed an easy target and an opportunity. The opportunity existed in the form of his Grandfather; a vulnerable and frail victim who was unlikely to resist and would be easy to overpower. The knowledge that his Grandfather also kept large quantities of money at his property probably fuelled his desire. Lastly Adult B had the means and the ability to commit the crime. He had keys to the property, the knowledge of his Grandfather's routine and where he hid his money. He had the stature to intimidate and overpower his victim if necessary.

529) To have prevented the attack on Adult A one of these elements would need to have been removed from the situation. Unfortunately no one, other than Adult B, was aware that his desire had become so palpable, and that he was willing to act. Once Adult B was intent on committing the crime, there was little anybody could have done to stop him.

530) In conclusion, Adult B was not on our radar as a risk. There was no history of violence or threatening behaviour towards Adult A and no warning that he would target his Grandfather. As the Panel were unable to pinpoint where the homicide could have been averted, they could only conclude that where there is the desire, opportunity and ability to commit the crime, together with the added aggravating factors of drug and alcohol misuse or limited agency involvement, there is every

possibility that a similar case presenting today could result in the same tragic consequences.

SECTION SEVEN: RECOMMENDATIONS [49]

This Domestic Homicide Review has identified a number of recommendations for local and national practice. For ease of reading, the recommendations have been separated into the following headings;

- Cornwall Recommendations
- National Recommendations

CORNWALL RECOMMENDATIONS (1 -8)

RECOMMENDATION 1: Devon and Cornwall Police should facilitate a Victim Support Homicide Worker at the very earliest opportunity (within 48 hours) to ensure that families are informed and supported through the criminal justice investigation and coroner's process.

Addressing Recommendation 1; Action 1

RECOMMENDATION 2: The Victim Support Homicide Worker commissioned to support families bereaved by homicide or manslaughter in Cornwall should be familiar with, and share, the Ministry of Justice Guidance for Coroners to assist with the understanding of coroner standards and help challenge unnecessary delays in releasing the victims' body for burial.

Addressing Recommendation 2; Action 2

RECOMMENDATION 3: Devon and Cornwall Police should ensure that Family Liaison Officers are allocated to both families of domestic homicide where blood relatives are related to both the victim and the perpetrator. As these families have sensitive dynamics, Devon and Cornwall Police should give consideration to counselling or pre-trial therapy to *both* families under the new Ministry of Justice

[49] Recommendations are linked to actions (to achieve the recommendations) – See SMART Action Plan

Code of Practice for Victims of Crime 2013.

Addressing Recommendation 3; Action 3

RECOMMENDATION 4: The pathway and referral route for pre-trial therapy and counselling in line with the Ministry of Justice Code of Practice for Victims of Crime 2013 should be mapped by Devon and Cornwall Police and the Safer Cornwall Partnership to ensure that support is accessible and available to reduce the risk of traumatic grief developing into Post Traumatic Stress Disorder (PTSD).

Addressing Recommendation 4; Action 4

RECOMMENDATION 5: (REDACTED) Crown Court should make provision for both families of domestic homicide where blood relatives are related to the perpetrator and victim. Every effort should be made not to discriminate against the perpetrators family if they are connected by blood to the victim and repudiate the crime. Family waiting rooms/areas should be considerate to the sensitive dynamics of interfamilial abuse.

Addressing Recommendation 5; Action 5

RECOMMENDATION 6: The Cornwall Drug and Alcohol Action Team (DAAT) should ensure that lessons from this domestic homicide review in relation to the lack of information provided to the family around Adult B's drug use are made available to GPs with an updated resource on where healthcare Professionals can access or print information, or signpost patients (and family members) for support.

Addressing Recommendation 6; Action 6

RECOMMENDATION 7: A protocol should be established for written correspondence between secondary and primary care services to identify which primary care clinicians should be named in all correspondence about a patient subsequent to a referral being made.

Addressing Recommendation 7; Action 7

RECOMMENDATION 8: The recently commissioned multi-agency domestic abuse training programme (2014 – 2016) should be made available to Cornwall Housing, Lifeline Services and Hartley Home Care to ensure Care Professionals are confident and competent to identify, assess and manage high risk domestic abuse and clients of these services benefit from the domestic abuse pathway in addition to adult safeguarding procedures e.g. IDVA support.

Addressing Recommendation 8; Action 8

NATIONAL RECOMMENDATIONS (9)

RECOMMENDATION 9: The Ministry of Justice Charter for Coroner Services, which sets out the benchmark for national standards, needs to be compulsory, not voluntary. This will help families and authorities to hold Coroners to account for non-compliance of national standards.

Note: Safer Cornwall cannot implement an action plan on behalf of the Ministry of Justice.

SECTION EIGHT

SMART ACTION PLAN[50]

No.	S	M	A	R	T
	Specific	**Measurable**	**Assignable**	**Realistic**	**Time-Bound**
1.	Devon and Cornwall Police should review its protocol and timescale for contacting a Victim Support Homicide Worker for bereaved families.	Aim to contact a Victim Support Homicide Worker (with consent) within 48 hours of the notification or suspicion of a murder or manslaughter.	The Public Protection Unit Lead for Cornwall will lead the implementation and monitoring of this protocol.	The Public Protection Unit Lead for Cornwall will need to be satisfied that the timescales for appointing a Homicide Worker are consistently applied and are workable and effective at an operational level.	The Public Protection Unit Lead for Cornwall will implement the protocol and feedback the outcome to the Domestic Abuse and Sexual Violence (DASV) Strategic Group by September 2014.
2.	The Domestic Abuse Coordinator for Cornwall should communicate with the Victim Support Homicide Worker to agree a strategy for empowering	Aim to reduce the local average time it takes to release a body for burial. Increase the confidence	The Domestic Abuse Coordinator for Cornwall will lead discussions in relation	The Domestic Abuse Coordinator will identify whether a mechanism for monitoring local	The Domestic Abuse Coordinator will report to the Crime Manager the outcome of

[50] The dates suggested within the SMART Action plan are based on the principle that the Home Office will approve the report by the 30th September 2014. Dates may be subject to change if the Home Office is unable to approve the report by the 30th September 2014.

	families to raise Coroner standards, specifically around the timescales for releasing the body of a victim.	of families to challenge Coroner decisions and performance in Cornwall Increase awareness of the Ministry of Justice Guide to Coroners and Inquests and the Charter for Coroner Services amongst Professionals who support bereaved families.	to the strategy for empowering families to raise Coroner standards.	performance against the deliverables can be created.	strategy discussions by October 2014.
3.	Devon and Cornwall Police should allocate a Family Liaison Officers to both families of domestic homicide where blood relatives are related to both the victim and the perpetrator. In such cases, consideration should be given to counselling or pre-trial therapy referrals for both families under the new Ministry of Justice Code of Practice for Victims of Crime 2013.	The Police protocol for making referrals under the Ministry of Justice Code of Practice for Victims of Crime (2013) will be reviewed and updated (if necessary) to include referrals for all blood relatives of interfamilial domestic abuse.	The Public Protection Unit Lead for Cornwall will lead the implementation and monitoring of this protocol.	The Public Protection Unit Lead for Cornwall will need to be satisfied that referrals for counselling or pre-trial therapy are consistently completed for the three priority areas under the Ministry of Justice Code of Practice for Victims of Crime 2013.	The Public Protection Unit Lead for Cornwall will update the protocol to consider sensitive interfamilial abuse and feedback the outcome to the Domestic Abuse and Sexual Violence (DASV) Strategic Group by September 2014.
4.	Devon and Cornwall Police and the Community Safety Partnership will map the referral route for pre-trial	Referrals will be monitored with take-up figures recorded and	The Public Protection Unit Lead for Cornwall and the Crime	The pathway/referral route will be easy for	The pathway will be mapped by September

	therapy and counselling for victims of the three priority areas outlined within the Ministry of Justice Code of Practice for Victims of Crime 2013.	reported to the DASV Strategic Group on a quarterly basis. Aim to reduce the risk of bereavement trauma developing into Post Traumatic Stress Disorder across Cornwall	Manager for the Community Safety Partnership will each nominate an individual to be responsible for mapping and facilitating counselling pathways. Devon and Cornwall Police will assume the lead for reporting counselling take-up to the DASV Strategic Group on a quarterly basis.	families to access. Consent to make a referral will be obtained. The service provider for counselling will report quarterly figures on the number of individuals who progressed to counselling. Existing free services will be explored but checks will be made on capacity to accept referrals.	2014. The first Quarterly report will be presented to the DASV strategic Group in December 2014 (and quarterly thereafter).
5.	Devon and Cornwall Police should seek to agree a working protocol with (REDACTED) Crown Court to make provision for both families of interfamilial homicide where blood relatives are related to the perpetrator and victim. The protocol should ensure family waiting rooms/areas are considerate to the sensitive dynamics of interfamilial abuse.	A protocol should be developed which outlines how arrangements will be made and who will be responsible for liaising with (REDACTED) Crown Court -by October 2014.	The Public Protection Unit Lead for Cornwall will nominate an individual to be responsible for this protocol.	The Public Protection Unit Lead for Cornwall will be accountable for the implementation of the protocol and its consistent application at an operational level.	The Public Protection Unit Lead for Cornwall will report the outcome of this action to the DASV Strategic Group by the end of October 2014.

6.	The Cornwall Drug and Alcohol Action Team (DAAT) will share the lessons from this case with Healthcare Professionals and provide General Practices with an up-to date directory of drug and alcohol services and literature to improve the information exchange between medical Professionals and Patients. General Practitioners will source information online during the consultation to ensure that patients (or concerned relatives) understand the purpose of any referrals and possible outcomes.	The lessons of this case will be shared with GPs by December 2014. An up-to-date resource will be made available to GP by December 2014. Website containing local information on drug and alcohol support will be updated by November 2014.	The Cornwall Drug and Alcohol Action Team (DAAT) will lead on this action and work in partnership with relevant agencies to ensure lessons are learnt and local information is relevant and accessible.	The Cornwall Drug and Alcohol Action Team (DAAT) will make information easy to access for patients and concerned family members. Information will include paper literature (for non-computer users). Pathways or signposting for support will accompany literature. Families will be provided with an option to feedback on literature and support services.	The Cornwall Drug and Alcohol Action Team (DAAT) will report the outcome of these actions to the DASV Strategic Group in October (to confirm that lessons from this DHR have been shared) and December (to confirm that resources are up-to-date and easily accessible via a variety of methods.)
7.	A protocol will be established for written correspondence between Mental Health Services and GP Services to identify which primary care clinicians should be named in all correspondence about a patient subsequent to a referral being made.	A protocol will be written, agreed and implemented by March 2015.	The Panel Members representing Primary Healthcare and The Cornwall Foundation Trust will each nominate a representative to lead on the introduction of a new protocol for	The protocol will identify which primary care clinicians should be named in all correspondence about a patient subsequent to a referral being made.	The nominated representatives from the Cornwall Foundation Trust and Primary Health Care will confirm that this action has been complete via a written update to the DASV

			written correspondence.		Strategy Group by April 2015.
8.	Multi-agency domestic abuse training should be made available to Cornwall Housing, Lifeline Services and Hartley Home Care to ensure that professionals are confident and competent to identify, assess and manage high risk domestic abuse and clients of these services benefit from the domestic abuse pathway in addition to adult safeguarding procedures e.g. IDVA support.	Number of places offered and accepted by said agencies recorded and reported to the Domestic Abuse Coordinator at The Safer Cornwall Partnership by Sept 2016. The Risk Evaluation and Coordination Hub (REACH) to record how many referrals are received from Cornwall Housing, Lifeline Services and Hartley Care Home pre and post training. Aim to increase the number of referrals to Domestic Abuse Services for elderly and vulnerable victims.	The Domestic Abuse Coordinator for Cornwall and the Isles of Scilly to liaise with the training provider and said agencies to facilitate places on the commissioned Domestic Abuse Training Programme.	A selection of dates will be offered over a two year period. Training will be delivered over two days. A register of delegates will record how many Professionals from Cornwall Housing, Lifeline Services and Hartley Home Care attended training. REACH will record the source of referrals from all agencies and compare data to previous years.	The Domestic Abuse Coordinator for Cornwall and the Isles of Scilly to confirm that training has been offered by Jan 2015. The Domestic Abuse Coordinator for Cornwall and the Isles of Scilly to confirm the numbers of attendees from initial offer by Oct 2016.

APPENDIX A: FULL CHRONOLOGY OF AGENCY CONTACT

Date	Source of Information	Family Contact - Child	Family Contact - Adult	Communication - within agency	Communication - external to agency	Response or Outcome	Comments
28 Feb 2010	Devon & Cornwall Police > Police OIS Log 643 Missing persons Computer System COMPACT MPPLY/1325/10	Adult B	C4a	C4a reports Adult B missing. Graded at medium risk.	C4 informs police "They are concerned re his sons state of mind - he has found out he has been badly bullied at work and in one incident the bully had Adult B up against a wall with a knife against his throat". Adult B had checked into hotel after spending night out with friends.	No 121a submitted. No apparent follow up to bullying allegation.	
02 Mar 2010	(REDACTED) Medical Centre >		Consultation between Dr P and Adult B;s Mother	The consultation record states: no previous history		Dr P queried a psychotic episode and made a	

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			who raised concerns	of mental illness: recorded that Adult B used street drug "Bounce" (slang term for Mephedrone) in December and developed oral blisters. Described erratic behaviour including a sudden disappearance; delusional perceptions (Adult B Mothers witnessed him seeing people who were not present) he was seen talking to a paper bag in the street; intermittently		referral for an urgent mental health assessment via a telephone conversation with CPN	

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				aggressive behaviour; his mother found carving knifes and cutlery hidden in his room.			
02 Mar 2010	Cornwall Foundation Trust > GP			GP make verbal referral to request assessment	Screening form completed Assessment made 03/03/10	Good response to referral	
03 Mar 2010	Cornwall Foundation Trust > CPT North Cornwall Community MH Team CMHT		Contact with ADULT B and Mother	Internal referral within CPT CMHT - EIS	Assessment of mental health made of under 18year old Decision to refer to Early interventions Service (EIS) for further assessment as they are specialist service for first presentation	Adequate assessment. Assessment does not record what ADULT B response is to referral to EIS. Assessing under 18year olds pro-active at time. Good Practice	

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					psychosis Referral made to EIS		
04 Mar 2010	Cornwall Foundation Trust > CPT North Cornwall Community CMHT			Letter sent CPT to Primary care	Letter to GP with outcome of assessment and referral to EIS Letter copied to ADULT B	Good Practice, timely letter	
09 Mar 2010	Devon & Cornwall Police > Police CIS Nominal Intelligence	Adult B	C4 C4a FR6 (NB)	FR6 (NB) in the evening went to Adult B's home. When C4a opened the door he demanded that her son Adult B gives him £150 because Adult B owed him a £100 and he owed someone else £150. He had a			

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				baseball bat with him and was making threatening gestures with it. C4 shut the door on him and heard FR6 (NB) call him a fat tosser or something like that. C4 advised Adult B to pay the £100.			
10 Mar 2010	Redacted Medical Centre > Cornwall Partnership Trust-North Cornwall Community Mental Health Team			Letter received from CPN working for Cornwall Partnership Trust dated 04.03.10. The letter addressed to the referring GP Dr P and copied to Adult B. The letter		Onward referral to the Early Intervention Service for further assessment	The Early Intervention Service specialises in the assessment and management of first episodes of psychosis.

Date	Source of Information	Family Contact - Child	Family Contact - Adult	Communication - within agency	Communication - external to agency	Response or Outcome	Comments
				detailed a mental health assessment which took place at (REDACTED) Resource Centre, (REDACTED), on 03.03.10 which was attended by Adult B and his Mother. The letter described Adult B's insomnia, poor memory and his fear that people were watching him and "out to get him"			
10 Mar 2010	Cornwall Foundation Trust > CPT EIS			letter	Letter sent to ADULT B offering appointment for assessment	appointment may be too short notice as on 12/3/10	
12 Mar 2010	Cornwall Foundation Trust			Tel call	Tel call to ADULT B on his mobile to	Good practice taking note of	

Date	Source of Information	Family Contact - Child	Family Contact - Adult	Communication - within agency	Communication - external to agency	Response or Outcome	Comments
	> CPT EIS				ask him to confirm if he is attending appointment today	short notice appointment	
12 Mar 2010	Cornwall Foundation Trust > CPT EIS			letter	Letter to ADULT B offering another appointment for 17/3/10	Good practice, timely letter	
17 Mar 2010	Cornwall Foundation Trust > CPT EIS ADULT B DNA appointment				EIT record their Plan to make contact with ADULT B	Persistent follow up to lack of attendance / contact	
20 Mar 2010	Devon & Cornwall Police > Police CIS Nominal Intelligence	Adult B	FR6 (NB)	Adult B has been having psychotic episodes since taking 'bounce' over Christmas he had to be rescued			

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				from a hotel in Plymouth and has been found sitting in the middle of the road in (REDACTED) at 0300 hrs talking to a paper bag believed he got the drug from FR6(NB). Adult B is being treated by his GP and they think he will recover from this with time.			
21 Mar 2010	Devon & Cornwall Police > Police CIS Nominal Intelligence	Adult B	FR6 (NB)	Adult B has paid FR6 (NB) the £100 that Adult B owed him for buying Methadone. Adult B and FR6 (NB) are now on speaking terms.		Mephedrone, at this time, was a "legal high". It has many street names such as 'bounce' and 'meow meow'	

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						It was made a class B drug under the 1971 Misuse of Drugs Act on 14/04/10.	
25 Mar 2010	Cornwall Foundation Trust > CPT EIS	Adult B	Tel call to ADULT B mother	Telephone call	Tel call to ADULT B mother in response to her tel call. Message left on answer phone		
14 Apr 2010	Cornwall Foundation Trust > CPT EIS	Adult B			Letter sent to ADULT B to enquire if he wished for another appointment	Good practice Persistent follow up to lack of attendance / contact	
12 May 2010	Cornwall Foundation Trust > CPT EIS	Adult B	Tel call	Tel call	Tel call to mother asking how ADULT B is, Lengthy discussion which is documented in		

Date	Source of Information	Family Contact - Child	Family Contact - Adult	Communication - within agency	Communication - external to agency	Response or Outcome	Comments
					detail mothers view of his current presentation, 'back to his normal self. Not using currently Decision made for mother to discuss with ADULT B if he wants an assessment EIS leaflet sent out to mother to assist with her discussion with ADULT B	Good Practice	
17 May 2010	REDACTED Medical Centre > LMC	Adult B		Dr M		Not relevant to this DHR	
01 Jun 2010	Cornwall Foundation Trust > CPT EIS	Adult B	C4a	letter	Tel call to ADULT B mother as she had not called EIS back as agreed	Good practice	

Date	Source of Information	Family Contact - Child	Family Contact - Adult	Communication - within agency	Communication - external to agency	Response or Outcome	Comments
					after talking to ADULT B Message left asking Mother to call EIS		
01 Jun 2012	Cornwall Foundation Trust > CPT EIS	Adult B			Multi-Disciplinary Team Discussion about discharge from service if no reply to messages/ letter Letter sent to ADULT B advising of this Offer of referral to service at any time if ADULT B was experiencing difficulties	Usual practice	
08 Jun 2010	Cornwall Foundation Trust > CPT EIS	Adult B	Letter to family C4a	Letter from CFT	Letter sent to ADULT B advising him that EIS are taking his non-	Good practice to send letter to service user,	

Date	Source of Information	Family Contact - Child	Family Contact - Adult	Communication - within agency	Communication - external to agency	Response or Outcome	Comments
					attendance as an indication that things are ok at present. Offer of assessment if things change, letter copied to family and GP	family and GP	
08 Jun 2010	Cornwall Foundation Trust > CPT EIS	Adult B			ADULT B discharged from service due to no contact / attendance from ADULT B		
11 Jun 2010	REDACTED Medical Centre > Cornwall Partnership Foundation Trust : Early Intervention	Adult B	C4a	A letter dated 08.10.12 was received from the Early Intervention Service, (REDACTED). The letter was addressed to Adult B and copied to Adult B's Mother and		The letter detailed Adult B's failure to attend appointment at the Early Intervention Service. The letter stated that the "non-contact" was	The GP who made the original referral for urgent psychiatric assessment, Dr P did not see this letter

Date	Source of Information	Family Contact - Child	Family Contact - Adult	Communication - within agency	Communication - external to agency	Response or Outcome	Comments
				GP. On receipt of this letter it was scanned and directed to Adult B's registered GP, Dr A		being treated as an indication that things are currently well. No further appointment was made.	
02 Sep 2010	REDACTED Medical Centre > MIU LGH		Adult B	Not relevant to DHR			
23 Dec 2010	REDACTED Medical Centre > LMC		Adult B	Nurse Practitioner			Not relevant to DHR
06 Jan 2011	(REDACTED) Medical Centre > LMC		Adult B	Nurse Practitioner			Not relevant to DHR
07 Feb 2011	(REDACTED) Medical Centre > LMC		Adult B	Dr R			Not relevant to DHR
17 May 2011	(REDACTED) Medical Centre >		Adult A			Home Visit	(REDACTED)

Date	Source of Information	Family Contact - Child	Family Contact - Adult	Communication - within agency	Communication - external to agency	Response or Outcome	Comments
20 May 2011	(REDACTED) Medical Centre > MIU LGH		Adult B	Letter: laceration to hand			Sharp knife at work (Butcher)
24 May 2011	(REDACTED) Medical Centre >		Adult A	Dr W		Home Visit	Dizziness
15 Jul 2011	(REDACTED) Medical Centre >		Adult A	Dr R		Home Visit	Head Pains
29 Jul 2011	(REDACTED) Medical Centre > LMC		Adult B	Dr W			Not relevant to DHR
03 Aug 2011	(REDACTED) Medical Centre > LMC		Adult B	Dr W			Not relevant to DHR
19 Aug 2011	(REDACTED) Medical Centre >		Adult A	Dr W		Home Visit.	Dizziness
22 Aug 2011	(REDACTED) Medical Centre >)		Adult A	Dr P		Home Visit Admitted to care home for respite care.	Acute confusional state
22 Aug 2011	Department Adult		Adult A	GP referral made	Rapid Assessment		Assessment

Date	Source of Information	Family Contact - Child	Family Contact - Adult	Communication - within agency	Communication - external to agency	Response or Outcome	Comments
	Care & Support				Team to respond		Completed
25 Aug 2011	Hartley Home Care > Hartley Home Care		Adult A		Commissioned by Cornwall Council to provide domiciliary care	Care Plan to start 30.08.11 comprising 4 visits per day	Next of kin is REDACTED – daughter-in-law
09 Sept 2011	Department Adult Care & Support		Home Visit by Case Co-ordinator to Adult A	Met Adult C3 on home visit		Assessment Completed	
20 Sep 2011	Department Adult Care & Support		Adult A	Met Adult C3 on home visit		Review & support Plan completed	
24 Sep 2011	Hartley Home Care > Hartley Home Care		Adult A		Cornwall Council reviewed care plan	Tea-time visits increased to 30 mins	
28 Sep 2011	Department Adult Care & Support		Adult A	Support Plan authorised		Passed to Long Term Team for annual review	
28 Oct 2011	(REDACTED) Medical Centre > LMC		Adult B	Dr W			REDACTED not relevant to this DHR
31 Oct 2011	(REDACTED) Medical Centre >		Adult B	Referral to Surgeon			REDACTED not relevant to this

Date	Source of Information	Family Contact - Child	Family Contact - Adult	Communication - within agency	Communication - external to agency	Response or Outcome	Comments
	LMC						DHR
25 Nov 2011	(REDACTED) Medical Centre > LMC		Adult B				Emergency surgical admission: REDACTED not relevant to this DHR
01 Dec 2011	(REDACTED) Medical Centre > LMC		Adult B	Healthcare assistants Practice Nurse			13 contacts for dressing and review of REDACTED not relevant to this DHR 01.12.11 to 20.12.11
02 Dec 2011	(REDACTED) Medical Centre >		Adult A	Dr B		Home Visit	Viral illness
19 Dec 2011	Devon & Cornwall Police > Police CIS BL/11/688 Continued		Adult B	ABH Common Assault	No evidence offered Conditional Discharge 12 months, £85.00	Adult C2b pleaded guilty to ABH.	

Date	Source of Information	Family Contact - Child	Family Contact - Adult	Communication - within agency	Communication - external to agency	Response or Outcome	Comments
	PNC				costs & £50.00 compensation		
21 Dec 2011	REDACTED Medical Centre >		Adult A	Dr A		Home Visit	Skin rash, carers present
28 Dec 2011	REDACTED Medical Centre > LMC		Adult B	Did not attend appointment			
03 Jan 2012	REDACTED Medical Centre > LMC		Adult B	Mr P			3 contact reviews to review REDACTED 03.01.12 to 13.01.12
09 Feb 2012	REDACTED Medical Centre >		Adult A	Dr J		Home Visit	Problems with toe
16 Feb 2012	REDACTED Medical Centre > Community Nurse		Adult A			Home Visit	Swollen feet
05 Mar 2012	REDACTED Medical Centre (LMC)		Adult A	Dr P			REDACTED

Date	Source of Information	Family Contact - Child	Family Contact - Adult	Communication - within agency	Communication - external to agency	Response or Outcome	Comments
21 Mar 2012	REDACTED Medical Centre > LMC		Adult B	Dr H			Review of REDACTED
11 Apr 2012	Devon & Cornwall Police > Police OIS Log 68 CIS EL/12/1701 & BL/12/371		Adult B	Aggravated vehicle taking, driving with excess alcohol and no insurance. Adult B takes C4's vehicle without his consent	Charged and remanded on bail. See 17/05/12		
12 Apr 2012	REDACTED Medical Centre > Community Nurse		Adult A	Dr A			Ankle swelling
12 Apr 2012	REDACTED Medical Centre > (LMC)		Adult A	Community Nurse		Home Visit	
17 Apr 2012	Department Adult Care & Support			Safeguarding alert received from CN (A&E		Start of Safeguarding	

Date	Source of Information	Family Contact - Child	Family Contact - Adult	Communication - within agency	Communication - external to agency	Response or Outcome	Comments
				sister REDACTED)		process	
17 Apr 2012	Devon & Cornwall Police > Police CIS Nominal Intelligence		C2b C3a	There might be cannabis growing in an address in REDACTED. There is a strong smell coming from the address which is frequented by a number of visitors. Occupant is C3a and her partner. Regular visitor is C2b.			
17 Apr 2012	Devon & Cornwall Police > Police OIS Log 40 CIS BL/12/399 Custody Record NSPIS		Adult A Adult B	Adult A is found by C1 seriously assaulted and having had £300 stole from his wallet. Names Adult B as the suspect.	Adult B arrested later the same day and charged GBH s20 and Theft. Pleaded guilty to Theft and remanded in custody at		

Date	Source of Information	Family Contact - Child	Family Contact - Adult	Communication - within agency	Communication - external to agency	Response or Outcome	Comments
	50BL/683/12				Cornwall Magistrates Court.		
17 Apr 2012	REDACTED Medical Centre > Letter from REDACTED Emergency Department		Adult A			Emergency admission – fractured cervical spine	
20 Apr 2012	Devon & Cornwall Police > Police		Adult A	Adult A deceased.			
17 May 2012	Devon & Cornwall Police > Police CIS EL/12/1701 & BL/12/371 continued PNC		Adult B	Driving vehicle with excess alcohol Driving otherwise than in accordance with licence. Using a vehicle while uninsured. Aggravated	Fine £100.00, Victim surcharge £15.00, one days detention, disqualified from driving 12 months. Licence endorsed. Fine £100, licence endorsed one days detention.		

Date	Source of Information	Family Contact - Child	Family Contact - Adult	Communication - within agency	Communication - external to agency	Response or Outcome	Comments
				vehicle taking. Breach of a conditional discharge. (19/12/11)	8 weeks in Young Offenders Institution, disqualified from driving for 12 months. No action.		
11 Jun 2012	Devon & Cornwall Police > Police CIS BL/12/399 NSPIS 50BL/683/12		Adult B	Adult B charged with Murder of Adult A	Remanded in custody to (REDACTED) Crown Court.		