Safe Durham Partnership Board

Domestic Homicide Review

DHR/002

An Independent Report concerning

The death of Adult A in 2011

Executive Summary

This document outlines the circumstances of the case, the findings of the review and the recommendations made by the Domestic Homicide Review Panel. A detailed chronology of events and action plan for recommendations can be found in the full overview report.

The death of Adult A was a tragic occurrence and the Safe Durham Partnership, who commissioned this Domestic Homicide Review, extend their condolences to the family and wish to thank them for their support in the undertaking of this review process.

1.0 Introduction

A review of this case was commissioned by the Safe Durham Partnership following the notification of the homicide of Adult A, which occurred in 2011, under local protocols. Although there was a delay in the formal notification to the Partnership, there has been no detriment to the overall DHR process.

The review has been undertaken in accordance with the statutory guidance which states that a Community Safety Partnership (CSP) has a statutory duty to enquire about the death of persons where domestic abuse forms the background to the homicide and to determine whether or not a review is required. This is in accordance with the provisions of the Domestic Violence, Crime and Victims Act 2004, Section 9. This came into force on 13th April 2011. The Safe Durham Partnership takes a robust view of the guidance.

The primary aim of the review is to examine the role of the agencies involved with the family over the specified period in order to identify and learn from any lessons and where needed, to alter practice in order to prevent or reduce the likelihood of similar occurrences.

The Safe Durham Partnership was formed in April 2009 following Local Government reorganisation. Prior to this there was a long history of partnership working across County Durham at both a countywide level and through the five districts based Community Safety Partnerships. The emphasis on partnership working across County Durham has been effective since the introduction of the Crime and Disorder Act in 1998. The vision is for a County where every adult and child will be, and will feel, safe. Working in partnership is essential in order to achieve this vision. A commitment to such principles has ensured real and tangible improvements to the quality of life of the community.

It is because of the strong commitments and clearly successful partnership working that the DHR Independent Chair is confident that any recommendations on lessons that need to be learned from this review will be acted upon accordingly.

2.0 Background

Adult A and Adult B are siblings and this case highlights the facts that the family are effectively grieving for the loss of two of their loved ones in particularly tragic circumstances.

The death of Adult A (who was 24yrs at the time of his death) occurred in 2011. During that afternoon Adult B (21yrs) was engaged in messaging on a social network site with someone she knew. In the communications she indicated that she wanted to go back to prison because she had no friends. During this social messaging, Adult B made various threats about stabbing 'someone' that night, although she did not indicate who. Later that same evening Adult A and Adult B were at a planned 'party' at Adult A's home. They and other guests were consuming quantities of alcohol. An argument broke out between Adult A and Adult B and during this Adult B took possession of a knife and stabbed Adult A causing him fatal injuries.

Adult B was sentenced to life imprisonment for the murder in 2012.

3.0 Process

The Safe Durham Partnership commissioned the Domestic Homicide Review and appointed an independent chair who is Claire Sullivan, a Consultant in Public Health for County Durham. Paragraphs 32-34 of the multi-agency guidance states "the review panel chair (and author, if separate roles) should, where possible be an experienced individual who is not directly associated with any of the agencies involved in the review". The chair is independent of all of the organisational areas of business that have supplied either IMR's or reports for the purposes of the review.

The domestic homicide review panel comprised of professionals from the following agencies

- Durham Constabulary
- Tees Esk Wear Valley NHS Foundation Trust
- Durham Tees Valley Probation Trust
- Youth Offending Service, Durham County Council
- Children's Services, Durham County Council
- Durham Dales, Easington and Sedgefield Clinical Commissioning Group
- County Durham and Darlington Foundation Trust
- Durham County Council, Education
- Low Newton Prison

A number of agencies were asked to provide reports to the panel from authors within those agencies who were also independent of the case. The agencies provided either Individual Management Reviews (IMR) or in the case where there had been limited contact with the

subjects and family, reports were requested for context. The Chair is grateful for both the quality of the submissions and the professionalism of the authors and agencies they represent.

The following agencies provided Individual Management Reviews.

- Durham Constabulary
- County Durham Youth Offending Service (CDYOS)
- Durham County Council, Children's Safeguarding Team
- Durham Tees Valley Probation Trust
- Tees Esk and Wear Valleys NHS Foundation Trust (TEWV)
- County Durham & Darlington Foundation Trust (CDDFT)
- HM Prison Service (HMPYOI)

The following agencies provided reports of contact.

- Durham County Council, Children and Adults Services (Education)
- NHS – GP Practice (Provided by the DDES CCG)

4.0 The purpose of the review

- To establish the facts that led to the incident in 2011 and whether there are any lessons to be learned from the case about the way in which local professionals and agencies worked together to safeguard the family.
- Identify what those lessons are, how they will be acted upon and what is expected to change as a result.
- Establish whether the agencies or inter agency responses were appropriate leading up to and at the time of the incident in 2011.
- Establish whether agencies have appropriate policies and procedures to respond to domestic abuse and to recommend any changes as a result of the review process. Domestic Homicide Reviews are not inquiries into how the victim died or who is culpable. That is a matter for coroners and criminal courts.

5.0 The scope of the review

- Seek to establish whether the events in 2011 could have been predicted or prevented.
- Consider the period of 8 years prior to the events (from 1st January 2003) subject to any information emerging that prompts a review of any earlier incidents or events that are relevant.

- Request Individual Management Reviews by each of the agencies defined in Section 9 of the Act, and invite responses from any other relevant agencies or individuals identified through the process of the review.
- Seek the involvement of the family, to provide a robust analysis of the events. In this case the mother and grandmother of Adult's A & B were those consulted.
- Take account of the coroners' inquest in terms of timing and contact with the family.
- Produce a report which summarises the chronology of the events, including the actions of involved agencies, analyses and comments on the actions taken and makes any required recommendations regarding safeguarding of families and children where domestic abuse is a feature.
- Aim to produce the report by the end of November 2013, to enable presentation to the Safe Durham Partnership Board, responding sensitively to the concerns of the family, particularly in relation to the inquest process, the individual management reviews being completed and the potential for identifying matters which may require further review.

6.0 Objectives

The purpose of the IMR's which form the basis for the DHR is to give an as accurate as possible account of what originally transpired in an agency's response to Adults A and B, to evaluate it fairly, and if necessary to identify any improvements for future practice. The IMR's have also assessed the changes that have taken place in service provision during the timescale of the review, given that practice goes back to 2003 and considered if changes are required to better meet the needs of individuals at risk of or experiencing domestic abuse.

The IMR's have been signed off by a senior responsible officer in each organisation who is responsible for the maintenance of and strategic ownership of any actions that are approved by the Safe Durham Partnership arising from the DHR. Where an agency IMR has made recommendations these will be managed by the respective agency and monitored by the Safe Durham Partnership Board through the Domestic Abuse Forum Executive group (DAFEG)

7.0 Facts and analysis

The family of Adult A reside in a small town with a population of approximately 12,000. They had previously resided in a larger town in the region.

Adults A and B are biological brother and sister and have an older half-sibling. The formative years of both Adult A and Adult B have been described by agencies in their IMR's as chaotic and challenging and that this lifestyle continued into their adulthood. Chaotic households are a term used by social workers in children's social care, stemming from serious case reviews of child deaths and abuse. Some of these characteristics which fit this case are low

income, poor housing conditions, children missing education, low take up of statutory services officers, criminality, substance misuse, and domestic abuse

The father of Adult A and Adult B was murdered when they were just 11 and 8 years of age respectively. Taking this event into context the nature of such a significant event occurring would certainly have been life-changing for the family unit and there is an indication from family and professionals that the murder of their father had a profound effect on the two adults.

Both adults and the elder male half-sibling, appear to have grown up in a home environment of abuse, neglect, and alcoholism and on occasion's drug misuse. It was identified that there was minimal income to the family household throughout and this appears to have contributed to the overall conditions that the family experienced. There is information that the maternal grandmother was a highly influential member of the family. There is also mention of tensions between the family and the local community with sporadic anti-social behaviour and violence occurring. The family home had been attacked and damaged on at least one occasion.

In addition there is evidence of domestic abuse between the mother and father of Adults A and B prior to his death that both Adults were exposed to and on occasions was witnessed by them.

Contact with support agencies although frequent was inconsistent if only on the part of the family in acceding to or recognising the intervention opportunities. A number of the individual management reviews identify numerous occasions where both adults and other family members failed or refused to engage with them despite the best efforts of the respective professionals.

In a meeting with the Chair of the DHR panel the mother of adults A & B admitted that her use of alcohol was a significant factor during the upbringing of all the children. In self-admittance of this fact she also expressed her concerns that whilst alcohol abuse is recognised by professionals it is an area where a lack of useful intervention existed at that time.

A significant family comment that perhaps exemplifies the manner with which the two adults in particular were brought up was that they believe that they did not need support from agencies. Although no single agency is cited they were, *"brought up not to let things get to you"* and all the support was maintained from *"within the family*". This is perhaps indicative of the fact that despite interventions, the family believed that they were actually in control when this was to the contrary and although the family were presented with opportunities they effectively did not take any support offered. This is a key consideration when examining the parenting skills that the interventions and support were aimed at.

8.0 Key Themes arising

In examining potential missed opportunities by practitioners the overview report identifies a number of occasions when interventions could have taken place or where events were perhaps handled too superficially. In 2003, a picture was emerging of two potentially troubled adolescents within a single household. Both were potentially at risk of suffering significant harm.

It appears that early opportunities to have intervened and accessed the family in an informative manner were missed or overlooked during which was a critical time in the development of Adult B and Adult A. Bringing professionals together at this stage would have identified the fragility of the family and the children's vulnerability. A number of agencies, including the Children and Adult Mental Health Service (CAMHS), Children Services, Education and CDYOS should have been in a position to have made an informed assessment of the family's needs. The family had been able to access services, but without any 'joining up' of the relevant issues by the services involved. If the family's needs had been put into context, and by asking the question of what happened 'then' and what happens 'now', the reviewer is confident that services would now be much more likely to take action in accordance with the principles of Working Together which have incrementally changed in the decade that this review has considered.

Adult B clearly was capable of violence and had served an initial prison sentence for violence in 2008. In this incident she appears to have defended Adult A. Although this didn't automatically trigger MAPPA considerations, it could have done if people had concerns. In the view of the review there was enough concern to justify a referral.

However in 2009, Adult B committed a much more violent attack, importantly that appears to be in defence of Adult A again. This attack could have led to a fatality and the sentence passed reflected what were the serious concerns for Adult B by the sentencing Judge.

Adult B was released from that term of imprisonment in 2010, less than 12 months before the tragic events of 2011. She declined medication on release, indicating that she would consult with her GP. No mechanism was put in place to ensure that this was followed through, although the medical records from the prison healthcare were provided to the practice GP. Had the cross referencing to her record been examined it might have been noted that she had a history of poor attendance and follow-up to her GP. A later confirmation check clarified that she had not attended her GP following release.

Adult B was re-called some 6 days later following her almost immediate breaches of the conditions of her conditional release.

The review fully accepts that this family were hard to engage. They did not appear in principle to be a 'hard to reach' family, yet barriers and hurdles were placed in the way of professionals from all agencies by the family. It is possible that a more dynamic and inquisitive approach by professionals could have made an impact and where working in closer partnership approaches could have been considered. The disclosure of specific facts is of concern when looking more holistically at how and when opportunities to look deeper into the family issues *could* have been undertaken but were not carried out. These are not considered by the review as systemic failures, but as frequently missed opportunities where more questions should have been asked by practitioners, managers and supervisors. The frequent lack of incisive review and being professionally more inquisitive and questioning and also challenging staff, is the reasoning for this observation.

The early efforts to intervene into the family were met with little apparent response from the family in general, particularly the mother of Adults A&B. It appears that the mother engaged when she felt that the circumstances necessitated or it was prudent to do so, but she did not appear to as evidenced in the IMR's always welcome professionals into the family. On occasions it appears that by her reactive approach to dealing with occurrences involving Adults A or B, she sought intervention as an immediate response to a given problem.

It is also fair to conclude that a number of agencies also did not go further in their efforts to intervene and support the family. Where the head of the family displays overt negativity on multiple occasions it should have the effect of creating far greater curiosity on the part of professionals and where more questions needed to be asked both within that agency and also in a multi-agency arena.

9.0 Conclusions

The conclusions reached are fair and balanced taking into account the relevant issues at the time and this review does not apportion blame, but seeks to understand where services were missing coordination and how this can be taken forward. The report will be shared with Durham's Children and Adult Safeguarding Boards for them to ensure relevant issues and learning are taken forward by each of them.

Predicting whether or not this homicide was likely to occur, and thereby be prevented, is a matter for debate. There was nothing overtly apparent to any of the agencies within the respective IMR's or from the family that gave any immediate indication of Adult B's propensity for violence against her brother. In fact in examining her previous offending of violence the opposite perspective is apparent as there is evidence that she was moreover very protective of him. The family commented that they were *"Like two peas in a pod".*

It is the reviews considered perspective that this homicide *could not* have been predicted.

The report does identify that there was a progression of the levels of violence used by Adult B as she moved into adulthood and although predicting homicide is not obviously apparent from the information available, other than her apparent intentions in the time immediately preceding the homicide, there is no doubt that her violent behaviour appeared to be escalating.

The review also acknowledges the contextual and process changes made since 2003 in particular that of safeguarding and the development of practice concerning tackling domestic abuse is considerably different to that which was available in 2003. There is little doubt that the instances seen herein would be unlikely to be repeated by applying current standards of reporting both within an agency and in partnerships in terms of available interventions.

This is also important for practitioners to understand so as to be consistent and where necessary persistent in their efforts to offer support.

The domestic abuse within the family, although identified and recognised by professionals was not holistically examined when it was encountered. The review recognises that the knowledge and dynamics of identifying and tackling domestic abuse has moved forward significantly and it does not propose to explore what could perhaps have been more thoroughly evaluated at the time. However had this been so, the opportunities to have worked more closely with the family may have 'broken down' the communication barriers that were present.

Care must be exercised to ensure that the purpose of ensuring that 'boxes are ticked' is not simply just that and that supervision and management oversight are able to look more closely at domestic abuse referrals to ensure that deeper issues are not overlooked. There can be no superficial approach made to dealing with domestic abuse, it requires evaluation and the amended domestic abuse definition now in use should be robustly applied by all those who have a duty to identify and safeguard the vulnerable.

To that extent there should be continued professional development made available to professionals through experts and practitioners. The wealth of knowledge and experience available within agencies, in particular the police public protection teams and independent advocates, should be utilised in supporting professional development across agencies. For example the training of GP's, primary care staff and other health professionals. Tackling domestic abuse continues to be a priority for professionals and the training and development of practitioner's knowledge base appears to vary across the Country.

There is scope for the local clinical commissioning groups and NHS England area team to commission work with the police and other key stakeholders, in continued training in the identification of abuse.

It is also important that good practice is identified and in this case the review has acknowledged this accordingly within the process

10.0 Recommendations

The individual agencies will be responsible for action plans within their own organisation and these will be reported back to and monitored by the Safe Durham Partnership Board through the Domestic Abuse Forum Executive group (DAFEG) to ensure that practice is improved.

There were a number of occasions where professionals in a number of agencies missed opportunities to ascertain a more informed background of the family and this lack of detail did not assist in the decisions made. For example whether or not the family home was a suitable environment for Adults A & B to remain in as issues were frequently observed, over a number of years. There were constant changes in the home environment that received comment in records, but without any significant detail and where up to date information to professionals was needed in order assist in their decision making processes. Professional curiosity should prevail throughout and this must extend to management oversight of the work.

Recommendation 1: An integrated multi-agency domestic abuse and sexual violence training plan is currently in development. This needs to identify the resources across the partnership to implement this plan including those sessions delivered by Harbour the commissioned Domestic Abuse Outreach Service. The plan needs to identify priority groups of staff for training and ensure a rolling programme is implemented. All training should emphasise the contributory factor of alcohol on domestic abuse as well the need for 'professional curiosity' and 'respectful uncertainty' rather than professional optimism.

Several Police forces have ‘leaflet packs’ available for persons arrested for alcohol related offences. This is in place within County Durham and is a subtle intervention opportunity and although the take up response cannot be qualified this is a good vantage point for intervention services to become involved and to encourage individuals to make self-referral. What is the current impact of this service? Alcohol screening in a criminal justice setting has shown to be effective, however further work to assess the impact of alcohol screening by custody staff is underway.

Recommendation 2: There is currently an initiative in custody suites where each individual identified in an alcohol related incident is subject to screening. The Alcohol Harm Reduction Group to evaluate the effectiveness of the current initiative, in custody suites in County Durham.

Durham Constabulary has a Central Referral Unit (CRU) which also has multi-agency partners within it; some of the partners would like to consider setting up a Durham partnership CRU. The processes that a MASH utilises in relation to information sharing is a capability to safeguard both children and adults. This is nationally regarded as good practice and has been highlighted in a number of National and Governmental reviews as best practice. The development of the CRU would really strengthen the partnership information sharing. MASH was designed and developed to create an environment where all statutory and non-statutory safeguarding partners are embedded together in an integrated workplace in order to deliver partnership assessment and decision making in relation to concerns about both children and vulnerable adults. MASH is designed to create the confidence and trust amongst all professions and partners to share both confidential and non-confidential information and intelligence in order that the best possible decisions concerning interventions or support can be made. MASH is designed to deliver three specific outcomes, in relation to robust information sharing;

- **Early identification and understanding of risk** – *Earlier and better decisions based on full partnership information picture*
- **Victim identification and intervention** *- the identification of unseen victims, the recognition of multiple notifications of concern falling below thresholds and the earliest identification of harm and risk to drive earliest interventions and support*
- **Strategic harm identification and reduction** – *Analysis and research across the rich partnership data within a MASH to identify the harm of today and tomorrow. Enables targeted intervention and support for best outcomes and the business case for commissioning of services against a true picture of harm*

The Durham Constabulary CRU is progressing really well, but still lacks a permanent health presence within. In the case of Adult's A & B and their mother the information that could have been shared through the MASH and was then risk assessed, would have been of a real benefit in keeping her and her children's life safer from harm. In this case and in many others, it would have been of real tangible benefit to have a relevantly experienced health professionals linking into the MASH.

Recommendation 3: Consideration is given to continuing the development of the Central Referral Unit with it becoming a fully functioning partnership CRU or Multi-Agency Safeguarding Hub (MASH) The priority maybe to first consider this for children then move to incorporate adults.

The release of offenders on licence from a custodial sentence is a regular occurrence and on occasions such licence conditions are breached in the early stages of that release. The National Probation Service (NPS) which will replace the current Probation Service Trust's will continue to be responsible for the management of offenders released early from their sentence in company with community rehabilitation companies depending on risk of harm.

All of the high risk will sit with NPS. They will be responsible for re-call where it deems it is in the interests of protecting the public. It is important that appropriate lines of communication continue to exist in particular between the police and the NPS. In this case there were two occasions when, it would appear, that the police did not alert the Probation Services Offender Manager of the circumstances of the contact with Adult B when she was 'on licence'. Both instances related to breaches of the conditions of her licence. These were instances where violence including a domestic violence incident between Adult B and her mother and where alcohol consumption was an aggravating factor. Such occurrences should be reported and acted upon accordingly if the safety of the public is to be maintained. A MAPPA meeting could have taken place which would have had the benefit of bringing together agencies to jointly share and discuss risk and this might have made a difference with a more holistic and cohesive view. It is fair to state that on the occasion of recall to Adult B in December 2010 that this was dealt with in a swift and effective manner, but this relied upon an effective notification process that was triggered by electronic data as opposed to agency dialogue.

The Durham and Tees Valley Probation Trust IMR makes no actual internal recommendations, however in relevant paragraphs of that report, it makes reference to improvements previously sought in respect of *"self-reporting" and "home visits".* The critical point to consider here however is that the areas identified within the probation IMR are of relevance to the bigger picture and it is important for example, to understand what is meant by *"the over reliance of self-reporting"* and how this perspective could affect other agencies action or activity. This requires clarification.

Recommendation 4: A) Durham Constabulary reviews its processes in relation to any breaches of licence to ensure that they are referred to the probation service.

B) That other professionals and agencies (where they are aware that NPS are involved) that have a relevant duty to ensure that information sharing protocols with the Probation Service [NPS] are robust and lines of communication are clear. The Probation Service [NPS] should be notified of any potential licence breach at the earliest opportunity.

C) The MAPPA Strategic Management Board to consider having within its management plan the setting of a thresholds policy for referring cases into MAPPA.

The second area of improvement was the need to undertake home visits. The respective IMR comments *"Another area for improvement was the need to undertake home visits, during supervision, where the offender is presenting as chaotic and there are concerns about safeguarding of children or domestic violence".* In this overview report, the fact that home visits by a number of agencies identified poor living conditions and also a background of potential domestic abuse in the lifestyle of the family, this makes such a statement a key factor and therefore this area for improvement should be carried forward under this DHR process as an action so that practitioners are fully aware of the need to have both

professional curiosity and not to be over optimistic that families are able to cope without help to improve their situation.

A frequent and recurring failure or refusal to attend appointments was a common thread within the family. In the majority of cases this was for healthcare appointments however there were a number of other occasions where the family failed to be at home for key visits. On most occasions this failure by the family did not trigger any significant follow-up action and the 'did not attend' (DNA) information was not specifically identified or shared between agencies. Such occurrences could be of importance in other agencies knowledge base and a mechanism of local notification to key agencies should be maintained for the purposes of assessment and joint intervention opportunities. In effect this would act as an 'information and intelligence' process.

Recommendation 5: The Safe Durham Partnership recommends that health providers in County Durham review their DNA policy and make sure that it is being appropriately applied. Health practitioners should be encouraged to identify those high impact families who persistently fail to attend and share this information with the referral agency as 'did not attend' (DNA) as part of this DNA protocol.

The IMR from Durham County Council – Children and Adult Services (Education) lacks significant information concerning the adults and their educational background, although it is indicated that both were excluded from school in their early teens. The mother of the Adults claimed that they were home tutored, however there is no information to verify the provenance of this claim. Education services have a significant role to play in the identification of early warning of problems within families and in this case the IMR from the Children's and Adults Safeguarding, responded to the concerns raised by the school attended by Adult B at that time. The education records do not replicate this information as it transpires that relevant records concerning Adult B were destroyed.

Taken in context, the review acknowledges that the parameters of the DHR would have excluded much of the early educational information however the agency should review its policy on destruction of files to ensure that it is robust and fit for purpose.

Recommendation 6: Durham County Council, Children and Adults Services (Education) reviews its policy and issues best practice guidance for schools concerning the ethical and statutory retention of files for those pupils that are from vulnerable groups in particular those excluded.

Although there is a need for improvement, contextually the manner with which problem families, as in this case, have been dealt with has changed in more recent years within partnership interventions. It is not the responsibility of a single agency to resolve and although case conferences and other forums offer opportunities for greater joined up

approach, each case must be regarded on its own merits or support becomes a menu based approach rather than a bespoke and needs based intervention.