Safe Durham Partnership Board

Domestic Homicide Overview Report

In respect of

Adult A

Adult B

Adult C

Adult D

Adult E

Adult F

Independent overview report author Russell Wate QPM MSc

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Section One

1.0 Introduction

1.1 This overview report is an independent consideration of the facts as have been established during the Domestic Homicide Review (DHR) in respect of Adults A, B, C, D, E and F (Adults E & F were children for the majority of the time of the review period). This Domestic Homicide Review was commissioned by the Safe Durham Partnership Board following the tragic events that occurred at County Durham in 2012 where four adults were shot in a short attack, three of whom suffered fatal injuries, having been inflicted by a known perpetrator. The perpetrator then apparently killed himself in the immediacy of the attack.

1.2 Although a criminal investigation into the deaths by the Durham Constabulary has taken place there will not be a criminal trial in connection with the homicides in view of the fact that the perpetrator died from a self-inflicted gunshot wound immediately following the killings. Formal inquests have been held into the deaths by the HM Coroner for Darlington & South Durham/ North Durham Districts and the overview author acknowledges that any observation made in respect of the deaths in this report is made on the basis of the facts as provided within the individual IMRs and personal briefings.

1.3 In parallel with these other processes is an independent investigation concerning the actions of Durham Constabulary in respect of the issuing of both a firearm licence and shotgun certificate to the perpetrator in the years leading up to the events. This review has been conducted by the Independent Police Complaints Commission (IPCC). There has also been carried out an internal firearms licensing review by Durham Constabulary. The overview author does not intend to replicate the investigations by the IPCC or the Constabulary however it should be noted that some of the recommendations and observations are featured within both this overview and that of these other reviews and specific commentary will refer accordingly.

1.4 The overview author has not met with any family members of the deceased parties in order to retain impartiality and in view of the fact that a number of members of the family had already been engaged within the review process prior to his involvement, through consultation and meetings with chair of the DHR panel Lesley Jeavons. The author however comments that there appears to have been exceptional contact with members of the family in what are clearly emotive circumstances and the panel chair should be complimented for such efforts. Matters raised by the family will consequently feature highly within this overview report.

1.5 The membership of the Safe Durham Partnership Domestic Homicide Review panel for this case consists of:

- Lesley Jeavons (Chair) - Head of Adult Care Durham County Council
- Paul Goundry – Police, Durham Constabulary
- Carole Atherton - NHS County Durham and Darlington
- Hazel Willoughby - Director of Public Protection, Durham Tees Valley Probation Trust.
- Fiona Nicol - Director of Wear Valley Women's Aid.

- Cath Siddle - Deputy Director of Nursing – North Tees and Hartlepool Foundation Trust
- Contributions to the overview report were received from the Chair of the Alcohol Harm Reduction Thematic Group of the Safe Durham Partnership Board.

1.6 The panel have met on a number occasions, in order to decide which agencies are to be required to supply IMRs, agree specific Terms of Reference and subsequently to examine the IMRs and chronologies. Additional meetings and consultations were held in order to agree the overview report and identify recommendations for the partnership.

Reason for conducting the review

1.7 In accordance with the provisions of the Domestic Violence, Crime and Victims Act 2004, Section 9, statutory Domestic Homicide Reviews (DHRs) came into force on 13th April 2011.

The act states that a Domestic Homicide Review should be a review

O*f 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'

For the purpose of this overview the definition of domestic violence is in accordance with the current cross-government definition:[1]

Any incident or pattern of incidents of controlling, coercive, 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.

Terms of Reference

The Safe Durham Partnership Board, agreed that in this case the deaths met the criteria of the Act, and commissioned a Domestic Homicide Review (DHR) with the following terms of reference (TOR) determined by the sub-group:

- *To establish what lessons are to be learned from the above domestic homicide regarding the way in which local professionals and organisations worked individually and together to safeguard victims. (This is the generic overriding principle of a domestic homicide review)*

1.8 The following additional terms of reference were applied by the panel both for the individual IMRs and this overview report[2].

[2] The overview will not specifically address the individual terms of reference directly although they will receive consideration throughout the report. The overview is satisfied that the specific references have been considered appropriately within the respective IMR's.

- *Whether family friends or colleagues want to participate in the review and if so whether they were aware of any abusive behaviour from the alleged perpetrator to the victim or vice versa, prior to the homicide.*
- *Whether there were any barriers experienced in reporting any abuse in County Durham including whether either party knew how to report domestic abuse should they have wanted to.*
- *Whether there were opportunities for professionals to enquire as to any domestic abuse incidents that were missed*
- *Whether either party had any history of abusive behaviour to an intimate partner and whether this was known to any agencies.*
- *Whether there were opportunities for agency intervention in relation to domestic abuse regarding (the subject adults) or their children that were missed.*

Timeline

The key dates for the Domestic Homicide Review IMRs are determined as being from the 1st July 2002 up to and including the dates of death in 2012.

Contributors to the review

1.9 The agencies invited to contribute to the DHR are:

- County Durham and Darlington Foundation Trust
- Durham Constabulary
- NHS County Darlington and Durham on behalf of Primary Care
- North Tees and Hartlepool Foundation Trust
- Newcastle College
- Durham County Council
- Durham County Council Housing Solutions (Chronology)

1.10 As already mentioned the IPCC have completed their review and an accompanied learning the lessons document. This focuses on the firearms licensing issues and procedures, but will also include some national learning.

1.11 Durham County Council, Children's & Adult Services contributed to the chronology. In addition Durham's Head of Education authorised a review of their records concerning the family and has confirmed that they hold no relevant information. Durham County Council's Social Care Direct and Initial Response Team supplied a report on how domestic violence notifications were dealt with prior to 2010 and how they are dealt with in 2012, which will be commented on later within this report.

1.12 The content of the Overview Report and subsequent Executive Summary has been anonymised in order to protect the identity of the victims, perpetrator, relevant family members, staff and others, and in order to comply with the Data Protection Act 1998. An Executive summary has been produced in a form suitable for publication with any redaction before publication with the agreement of the panel and commissioning authority.

Subjects of the review

1.13 The individuals subject of the review, which although is primarily focussed on the relationship between Adults A & B, is much wider so as to include the other two adults, C and D who also died at the hands of perpetrator, and also the children of Adults A & B, Adults E and F.

They are outlined below:

Deceased:	*Adult A*
Children:	Known within this report as *Adult E*
	Known within this report as *Adult F*
Alleged perpetrator:	*Adult B*
	Father (to Adult F)
	Step Father (to Adult E)

Deceased:	*Adult C* Adult C is the sister of Adult A
Deceased:	*Adult D* Adult D is the daughter of Adult C and niece of Adult A

It should be noted that other reports into this incident use similar codes to identify different people for example the IPCC report. However all of the agencies within the Safe Durham Partnership have used the above code to identify the individuals involved in this DHR.

Domestic Homicide Review Chair & Overview Author

1.14 The Chair of the Domestic Homicide Review Panel is Mrs Lesley Jeavons who is employed by Durham County Council. Consideration was given to the revised Multi-agency Statutory Guidance in determining who should be appointed as panel Chair with significant importance being placed on the impartiality, skills and expertise of the individual. Ms Jeavons had no involvement with key personnel in Durham Constabulary in relation to Firearms Licensing prior to undertaking the role of Panel chair. She was not employed by any of the agencies who submitted IMRs and had no line management responsibility for any individual or functions of those agencies.

The overview is supplied by RJW Associates, and the overview author is Mr Russell Wate QPM MSc. He is totally independent of any agency within the Durham County area. He is a retired senior police detective, who is very experienced in the investigation of homicide and domestic homicide. He has contributed to a number of national reviews, inspections and

inquiries, as well as being nationally experienced in all aspects of safeguarding children and public protection. He was formerly a member of the ACPO Homicide Working Group and has national expertise in the investigation of child deaths.

The Safe Durham Partnership Board is satisfied that sufficient challenge, independence and objectivity was evident between the panel chair, author and agencies involved in terms of their role in carrying out the review.

Objectives

1.15 The purpose of the Individual Management Reviews (IMRs) which form the basis for the DHR is to give an as accurate as possible account of what originally transpired within each respective agency's response to Adults A, B, C, D, E and F, to evaluate it fairly, and if necessary to identify any improvements for future practise. IMRs also propose agency specific solutions which are likely to provide a more effective response to a similar situation in the future. The IMRs have also assessed the changes that have taken place in service provision during the timescale subject of the review and considered if changes are required to better meet the needs of individuals at risk of or experiencing domestic abuse. Such contextual changes are not discussed in specific detail within this overview, other than where it is considered necessary by the author of this report and where such change has led to significant change in practice that requires comment, both positive and negative.

1.16 This report is based on IMRs commissioned from professionals who are independent from any involvement with the victims, family or the alleged perpetrator. The report author has indicated whether there is confidence in the findings of the respective IMR. The IMRs have been signed off by a responsible officer in each organisation who will also maintain the strategic ownership of any individual agency action plan[3].

1.17 The report has been shared with key members of organisations, and the coroner. It has also been shared with the Home Office Quality Assurance Group. (Their comments are referenced within the letter published alongside this report which is included within appendices). The contents have also been shared with both families however the report will not be disseminated until authority has been received from the Safe Durham Partnership Board. In order to secure agreement, pre-publication drafts of this overview report were seen by the membership of the review panel, commissioning officers and the membership of Safer Durham Partnership Board. The individual IMRs will not be published. The publication of the executive summary for this Overview report will be timed in accordance with the conclusion of any related proceedings and any other review process.

1.18 This overview report and/or executive summary will be made public and the recommendations will be acted upon by all agencies, in order to ensure that the lessons of the review are learned at the earliest opportunity.

1.19 Family members of the respective adults will be consulted about that report in accordance with the view of the Safe Durham Partnership Board and such consultation should take place prior to publication of the respective report and executive summary.

[3] Process of evaluation and progress in order to ensure that these actions are completed will be the remit of the Safe Durham Partnership.

2.0 Background information

2.1 It must be highlighted that the Domestic Homicide Review looks back over a period of almost 10 years and that organisational practices within Durham how the respective agencies deal with domestic abuse have improved greatly and developed expeditiously. The multi-agency partners and the relevant voluntary agencies must be congratulated for this however it must bear in mind that relevant comment needs to be made at each appropriate incident throughout the timeline of the DHR.

2.2 The deaths that occurred to initiate this DHR relate to the use of a shotgun, and the fact that Adult B was lawfully in possession of both shotguns and firearms. In essence there is little difference between the two, other than it is the type of weapon that is being authorised on the basis that shotguns are issued by the Chief Officer of Police (either as grant or renewal) who must be satisfied that the applicant can be permitted to possess a shotgun without danger to the public safety or to the peace. There is no requirement to detail why each particular gun is required providing that they are actually defined as shotguns.

Firearms - Applicants for firearms have to show 'good reason' for possession of each and every firearm as well as satisfying the chief officer that they are a fit person to be entrusted with the firearms without danger to public safety or the peace. When looking at the "fit person" area, facts such as conviction history, referees, ability and safety in use and storage of firearms are taken into account, among other checks.

Once the certificate is issued, the applicant is required to continue to prove "good reason" or the Chief Officer of Police may have grounds to revoke the certificate.

The difference between a firearm and a shotgun: a firearm has a rifled barrel and fires bullets. A Shot Gun is a smooth-bore gun (not an air gun), which Has a barrel not less than 24 inches in length and a bore not exceeding 2 inches in diameter, Either has no magazine, or has a non-detachable magazine incapable of holding more than two cartridges Is not a revolver gun. If you hold a shotgun certificate, you will not necessarily be authorised to hold a firearm. The actual 'meaning' of each relies upon the conditions placed upon the holder by the police, i.e. the number of weapons authorised, where held, ammunition permitted and any special conditions attached to the holder as opposed to the certificate/licence, although these will be specified on the respective authority.

2.3 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 Community Safety Partnerships. The overall 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. There is a strong history of partnership working across County Durham since the introduction of the Crime and Disorder Act in 1998. A commitment to working in partnership has ensured real and tangible improvements to the quality of life of the communities[4].

2.4 Crime in County Durham is currently at its lowest levels since 1983 and it has a crime rate which is well below the average for England & Wales. The repeat victimisation rate for domestic abuse remains well below the target set by the Home Office. Levels of domestic

[4] Safe Durham Partnership plan 2011-2014

abuse related incidents reported to the police have remained relatively stable with 10,209 incidents in 2009/10, 10,425 in 2010/11 and 10,865 in 2011/12.

2.5 The Safe Durham Partnership is committed to preventing crimes against all vulnerable people, and where they do occur it will provide the victims with necessary support. They will also take strong enforcement action against perpetrators. The repeat rate of domestic violence for cases subject to the Multi-Agency Risk Assessment Conference (MARAC) process is low within County Durham. Reducing repeat victimisation for high risk cases is a key role for the Safe Durham Partnership which has ensured that MARAC has been implemented throughout the County Durham area. The Partnership is committed to creating a culture where domestic abuse victims have the information and confidence to ask for help.

2.6 Alcohol harm reduction is also a priority for the partnership. Alcohol is identified as a significant factor that cuts across all other priorities. Alcohol and substance misuse are problematic in their own right and are known factors that aggravate other crimes and disorder. They can lead to people becoming more vulnerable to offences of assault, while many victims of abusive partners suffer problematic substance misuse themselves. Alcohol misuse appears to be a strong characteristic of Adult A & B's life.

2.7 Within the Safe Durham Partnership Plan for 2011-14 are two areas relevant to this review:

1) Improve the safety of victims and reduce repeat incidents of domestic abuse.
2) Reduce the harm caused by alcohol.

It is because of the strong commitments and successful partnership working as highlighted in this plan, that the overview author is confident that any recommendations on lessons that need to be learned from this overview report will be acted on in an effective and timely manner.[5]

2.8 The deceased victims and the perpetrator did not all reside at the same residential premises, although all died at the same address, which was the home of Adult A and Adult B situated in County Durham. Adults A, B, E and F had lived at that address for approximately 15 years. Adults C and D lived in separate accommodation and were in their company following a social event at a local sports club.

2.9 On the evening of Sunday the 1st January 2012, the police responded to reports of a shooting at County Durham. The alarm was raised by a surviving victim of the shootings, Adult E, who had escaped from the house by jumping from an upstairs window despite being wounded during the incident. When officers entered the home they discovered the bodies of the three victims and the perpetrator. Although Adult E was injured during the attack, Adult F was physically uninjured. The overview report recognises the significant psychological effects that the family and in particular that the surviving adults have suffered. Forensic and witness evidence suggests that Adult B shot Adult A first, then turned to shoot Adult D followed by Adult C and then finally turned the weapon on himself. Adult E was injured as a result of the shotgun spray hitting her in the attack on Adult D.

[5] The overview acknowledges that action in respect of recommendations remains the mandate of the Safe Durham Partnership and that not all recommendations may be adopted.

2.10 Later post mortem examinations concluded that all four of the deceased had died from injuries that were consistent with the use of a shotgun and this was attributed to a single weapon. Adult B was the holder of both a shotgun and firearms certificate permitting his lawful possession of a total of six (6) weapons. All the firearms held were recovered following the deaths including the shotgun used in the murders and subsequent apparent self-inflicted injuries.[6] There were no illegally held weapons recovered and there is no suggestion that Adult B held any weapons or ammunition illegally or in contravention of his respective authorities.

2.11 The deceased are all members of the same family. Adults A & B were in a relationship and although not married to each other had lived together for approximately 19 years. Living within the same household were Adult E, natural daughter of Adult A, and Adult F, the natural son of adults A and B. The others who died in the incident were Adult C, the sister of Adult A and Adult D, the niece of Adult A and the daughter of Adult C. Adult E survived the attack, although injured, as did Adult F who was not physically injured.

2.12 At the date of the incident 2012, Adult E was 19 years of age and Adult F, 17 years of age. The overview author will also consider whether actions accorded with the guidance in 'Working Together' to Safeguard Children, [78] in order to examine the relevancy of the children and the children's voices within the reporting period of the review.

2.13 A formal homicide (murder) investigation was commenced by the Durham Constabulary. It was quickly apparent that the police were not seeking any third party in connection with the deaths and HM Coroner for Durham was notified accordingly that although a murder investigation was being undertaken that it was unlikely that there would be any criminal proceedings.

2.14 HM Coroner for County Durham consequently requested that the Durham Constabulary prepares a full report for the purpose of the inquests concerning the deaths. The Inquests concluded on the 8th of March 2013. And the verdict was; Adult A- Unlawful killing. Adult B- Took his own life. Adult C- Unlawful killing. Adult D- Unlawful killing.

[6] This has been formally determined by HM Coroner for Durham. The author however also makes this professional judgement based upon the facts of the case as known from the relevant material provided.

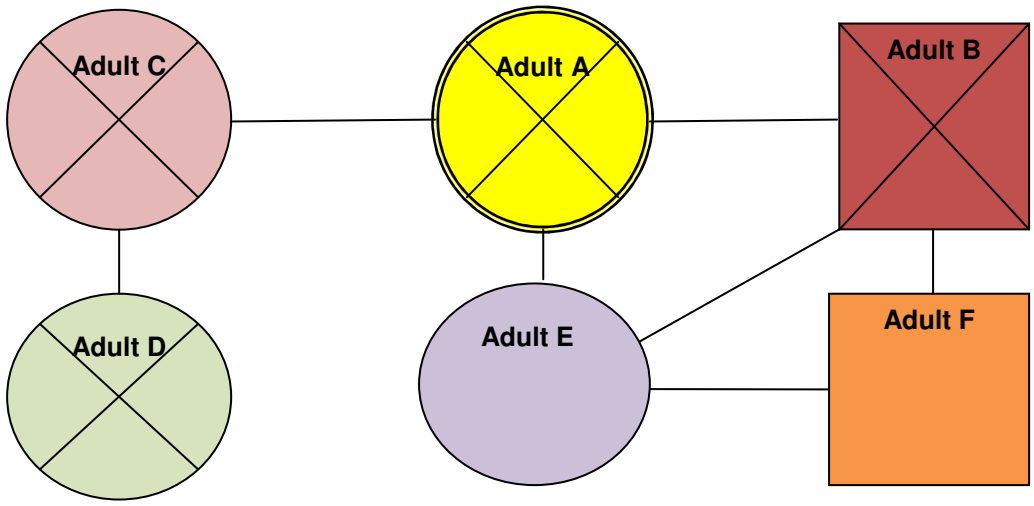
[7] In consideration of the fact that the individuals were children within the review period dates as determined within the terms of reference.

[8] HM Government 'Working Together to Safeguard Children' 2010. This is statutory guidance arising from the Children's Acts of 1989 and 2004, which gives guidance on to agencies on how to work together to safeguard children.

3.0 Chronology

3.1 The author is grateful for and refers to the integrated chronology provided by the Safe Durham Partnership. Any reference made to the chronology will be contained within the body of this overview report and is not subject of separate comment.

Genogram.



Section Two

4.0 Summary analysis of the Individual Management Reviews (IMR)

Although the reviews are discussed in more detail within the analysis of this report this is a brief summary of the information and contents of the individual reports from those agencies requested to provide an IMR.[9]

Durham Constabulary

4.1 The IMR provided a framework of background into the family and gave a good indication of the systems and processes in place during the relevant review period, concerning how the force dealt with matters of domestic abuse, the recording and dissemination of information both internally and integration with other agencies within this area of business. The well-constructed report examined a number of domestic abuse related incidents within the immediate household and was able to provide an analysis of the incidents and outcomes. The author also looked outside of the reporting parameters to examine background and pre-cursor information that is of relevance. Contextual and organisational change also receives comment. A number of actions are recommended together with an associated action plan. The author refers to a sister of Adult A being told by her that she believed that Adult B would kill her one day. This disclosure by her sister was

[9] 5 agencies have contributed by an IMR in accordance with the requests from the panel chair. Reports from other agencies are referenced accordingly.

never shared with other family members, friends or professional bodies by that individual until after the tragedy. The IMR does not look at analysis concerning the issues surrounding firearms in view of the parallel process being conducted by the IPCC and also their internal review of firearms licensing. The IMR was compiled by two members of the Constabulary independent of the police investigation.

4.2 The indications are that there was a potential pattern of domestic abuse, predominantly against Adult A that can be traced back to mid-2002[10]. The IMR author has taken steps to interview staff who attended the historical incidents for the IMR. This perspective is recognised as being good practice across a range of disciplines where activities such as personal interviews, written responses and questionnaires can frequently add value to the overall report process. It is of note that the Durham Constabulary has made significant progress in the processes involved with dealing with victims of domestic abuse in more recent years and in line with national best practice and the IMR indicates this historical perspective in analysing these differences. The police are not alone within the multi-agency partnership in their service delivery improvements in dealing with victims of domestic abuse; however their role in these improvements should be seen in a positive light.

North Tees and Hartlepool Foundation Trust (NTHFT)

4.3 The IMR has been written by an independent author who has previous experience of reviews. This IMR focused specifically on Adult A and Adult B. The review document was well structured and again good practice highlights the interview of key individuals within the process. It also identifies that although it has not been possible to identify clinicians from poorly appended signatures on records that system and processes introduced more recently has ensured that both signatures and printed names are endorsed on medical notes and records. This is good practice for other agencies to consider taking forward. The NTHFT also indicates that accident and emergency department notes in connection with three instances in this case could not be found and consequently only very limited information was available which could not be assessed fully unless this was otherwise supported by relevant notes or records from other contributors.

4.4 The IMR comments that it is of note that the circumstances of the contact with Adults A & B by the professionals within the Trust presented little insight to the IMR author into the background of the individuals or family information, although concerns of excessive alcohol consumption by both of them were frequently highlighted. The lack of information and insight is possibly a unique perspective given other agencies contacts and the fact that the accident and emergency notes are separate from the medical records in the Trust. The IMR acknowledges that that each individual's records are stored separately and there is no system which 'marries up' members of the same family. The IMR identifies that in respect of the relevant children that there was '*No information relevant to this IMR'*. However the overview author urges caution in respect of a generalisation made of '*that all we can reasonably expect is for accident and emergency staff to do as standard is to provide immediate response to the presenting complaint and 'signpost' to appropriate services'*. The overview author does acknowledge that this standard is in keeping with the GMC guidelines at that time for A&E staff, and signposting did take place. However If domestic abuse features as background to the presenting complaint, this should be acknowledged and

[10] July 14th 2002 is the first reported/recorded incident of domestic abuse.

appropriately dealt with and signposting to other services should always take place, within the trust the author notes the positive improvements that have taken place.

NHS County Durham and Darlington (NHS CDD) on behalf of Primary Care

4.5 The IMR indicates the extensive review that was undertaken of relevant files and records for the key individuals and details the manner with which interviews were conducted with relevant staff. This is good practice and ensures that perspectives of practitioners are obtained who have first- hand knowledge of the individuals, systems and processes. This IMR is considered by the overview author as a particularly well-structured report and an excellent example of how to compile and present an IMR.

4.6 The IMR provides some earlier yet relevant medical background concerning Adult A which indicates that she was suffering from depression in early to mid-2002 and was referred to counselling, where she failed to engage with that counselling. Although this falls slightly outside of the review period, the IMR author has been wise to ensure that this historical information is included as this fact is a significant feature and not one that her close family have alluded to, if indeed they were specifically aware. The fact that Adult A attended the GP practice on 44 separate occasions during the review period, which statistically is below the national average, did not at that time; raise any significant concern over the level of domestic abuse. It is of note that the information contained within the medical records has supported and helped to place a greater emphasis on the validity and provenance of the information contained within the interviews of her close family.

County Durham and Darlington Foundation Trust (CDDFT)

4.7 This IMR is relatively short and again is well-constructed however it should also be taken into account that the contact with specific individuals in this case was limited to just that by Adult A on a single occasion only. Academic analysis included within the report is clear in that it exposes the single apparent failing in this case, one that could have opened up to intervention opportunities by other agencies. It does also however identify that agencies and practitioners rely on the co-operation of victims and in this case the victim was unwilling to step outside of her apparent reticence and declined the offer of [in particular] police intervention. This reluctance on the part of Adult A is a key factor when examining the respective IMRs.

4.8 The author of this IMR identifies that in the case of the Trust that there was a significant child safeguarding issue arising from this single contact and this exemplifies the need for all agencies to ensure that there is a joined up approach. This frank account provides a clear insight into how easily a comment can be missed and where practitioners need to be alert to thinking ‘outside the box’ by not dealing with just the immediate and obvious facts, but the ancillary issues. Moreover the child’s voice was not heard.

Newcastle College

4.9 This IMR briefly examines the interaction between Adult E and the safeguarding officers at the college in respect of Adult E’s disclosures about “*problems she was having at home”*.

4.10 An interview with a key staff member indicated that in late November 2011 Adult E had disclosed very limited information concerning violence within the family household between her step father Adult B and her mother Adult A.

Other agencies: Non-IMR

Durham County Council

4.11 A contextual statement has been submitted by Durham County Council to the review. It details changes to the management of domestic violence (DV) notifications from Durham Constabulary prior to April 2010 when the front of house service (Social Care Direct)) covered both Children & Adult referrals and was managed in another part of the Council, to its current operating model, where a separate age specific service exists.

Prior to 2010 notifications of concern in respect of DV incidents were faxed to Social Care Direct, where they were screened and prioritised by qualified social workers within the team.

Following an independent review in 2009 where deficits were identified in relation to decision making, recording and the retrieval of historical information, the management of the service reverted back to Children & Young Peoples Services for a short period of time. In April 2010 a separate age specific service was established for both Children & Adults which was managed within respective social care services and an arrangement was established where both services have qualified SWs co located with police colleagues within the Central Referral Unit (CRU). This ensures that decisions about the level of potential risk to victims are jointly analysed and agreed between agencies.

Diversity

4.12 Each of the IMRs comment upon ethnicity and diversity within the respective narrative although this is not discussed in any particular detail. A recommendation concerning the inclusion of all aspects of diversity is made within this overview. There is however no indication that any specific issue of diversity has had an effect on how any of the victims or wider family were dealt with at any time.

5.0 A summary of the facts in this case

5.1 The information contained within the individual IMRs indicate that Adult A and Adult B met in 1992/3 and shortly afterwards they set up home together. Their relationship appeared to be loving and amicable, with the child (Adult E) of Adult A's first marriage being integrated into the family unit. In 1994 the couple had a son together (Adult F) Interviews with key family members indicates that the family circulated initially widely within the extended family group although as time progressed Adult A appeared to withdraw more from her social circle although this was initially put down to the fact that she was a doting mother to both her son and daughter who were her priority.

5.2 There is an implication from members of her immediate family that suggests that Adult A's mother and siblings were subjected to repeated domestic abuse and assaults at the hands of the father, the full extent of which cannot be corroborated. This is also commented upon by other members of the family and in some limited commentary within early GP

records. Both of Adult A's parents are deceased and such information did not form part of the terms of reference, however such family background is important in consideration of historical causation and psychological effects that such an upbringing can have on individuals in particular arising from their childhood experiences.[11] There is no information to indicate or suggest that Adult A was the victim of domestic abuse within her former marriage and it is indicated that the separation was amicable. The father of adult E maintained contact with his daughter following the separation. This again falls outside of the reporting period but is relevant to the wider terms of reference.

5.3 It is known that Adult A had a single criminal conviction for a serious assault that occurred in 1994. The foundation of this is that following a dispute with a female friend, she struck the victim in the face with a glass causing a significant injury. At the time of that incident she was in the company of Adult B and this incident receives comment from members of the wider family in consultation with the review. Adult A received a significant custodial sentence for this assault and served 12 months of the imposed 30 month sentence. It is not therefore unreasonable for the overview to surmise that she was capable of losing control, a point that other family members of Adult B made known and such disclosures have been given due regard by the overview.

5.4 It is also a fact that Adult B had a single recorded caution for assault[12], and it is significant that the victim of that assault was Adult A. It is again reasonable to surmise that Adult B was also capable of losing control. It is also noted that both Adult A and B were arrested together on the 6th August 1999 for an offence of Common Assault against a neighbour and although charged it transpires that the case did not proceed further. No additional information concerning this incident has been provided to this overview within the police IMR and consequently the circumstances have not been evaluated. It is acknowledged that this does fall outside of the reporting dates as determined by the DHR.

5.5 The review accepts as a fact that Adult A was pregnant at the time of sentencing for the offence in 1994 and gave birth to her son, Adult F, whilst serving her custodial sentence. Adult F appears to have spent the first six months of his life with his mother in a prison environment before being cared for by members of the family pending her release from her sentence on licence[13].

5.6 It is apparent that there was regular contact between Adult A and her siblings in particular Adult C and another sister. It is recognised that from the content of the IMRs that the relationship between the three was the closest within the wider family unit and that as a consequence it is not unfair to surmise that the information shared between them was likely to have been extensive and is capable of some form of corroboration in part when examining the facts. It would appear that Adult A was particularly close to Adult C, whom she confided in throughout what appears to be a turbulent relationship with Adult B and that Adult C would frequently intervene in support of her sister. It is also apparent that Adult C and Adult B disliked each other.

5.7 Looking at the events of the reported incidents of domestic abuse between Adults A and B it is perhaps prudent to commence with the first reported incident attended by Durham

[11] Hidden Hurt, domestic abuse information. http://www.hiddenhurt.co.uk/index.html
[12] This matter is of relevance when examining the shotgun/firearms perspective.
[13] From information provided by family members. This has not been qualified by referring to Home Office Prison records.

Police and examine the respective links within agencies where they existed in chronology. This overview of the dates will consequently not be in strict chronological order.

5.8 The earliest reported domestic related incident for the time period as specified within the terms of reference for this DHR, where the police were involved occurred on the 14th July 2002. This is in contrast to the information available from the GP records, which suggest that the indicators of potential abuse had manifested as early as April 2001 within visits made to the GP practice by Adult A, although there are no details or indication of actual physical assault contained within the records. Visits to the GP practice continued in a similar vein up to and then beyond this reported incident of July 2002 by Adult A.

5.9 The incident of the 14th July 2002 occurred as a consequence of both Adult A and Adult B having been drinking all day.[14] The extent of the incident appears to be that Adult A threw a plate of food over Adult B who reacted by threatening violence against her. The police officer attending arrested Adult B in order to prevent a breach of the peace and he was held overnight and was released the following day where he was taken to his mother's address. There does not appear to have been a formal complaint made by Adult A and the officer took what appears to be appropriate intervention action[15].

5.10 Due to the nature of the incident the police domestic violence officer referred the incident to the Child and Family Protection Unit and Social Services within 48 hours. The risk was assessed by police as 'not being perceived as high'. Children were noted as being present and witnessing the incident. At this time Adult F and Adult E were aged 7 and 10 respectively. The GP practice records indicate that Adult A visited them on the 25th July 2002 with the notes, *"assaulted recently by partner, police and solicitor involved. Large lumps of her hair were torn out. Scalp very tender".* As this visit was 11 days after the incident the circumstances as they appear within the GP's notes tend to suggest that this was in fact a separate incident where there had been actual as opposed to threatened violence, taking into account the injuries seen by the GP. [At a subsequent IMR writers group meeting concerning this DHR it was also strongly felt that this was in fact a separate incident] Adult A was referred for counselling. This incident should have flagged appropriate child welfare considerations between the respective agencies. This is a clear safeguarding issue for the children as well as Adult A and should have been treated as such. The indicators in this (these) cases are alcohol, domestic abuse and violence and the presence of children at the time.

5.11 Records of the 3rd August 2002 between the counsellor and GP indicate that Adult A had disclosed during consultation that her relationship was abusive and that her *"partner goes out a lot, stays out all night, violent and controlling towards her."* It also disclosed the apparent hatred that Adult A had for her father from witnessing such similar violent and aggressive behaviour against her mother at the hands of her father during her childhood. It further identified that Adult A consumed '*excessive amounts of alcohol'* in order to help her forget. It is interesting to note that at this stage it was also disclosed by Adult A that Adult B was frequently staying out of the house of his own volition. Again this documented record is in contrast to Adult B's sibling's claims that he stayed away because of the intimidation and

[14] There are frequent references to the excessive consumption of alcohol and when incidents appear to be triggered following consumption by one or both adults.

[15] Positive intervention action by officers will generally involve making an arrest where appropriate powers existed.

abuse that he was suffering from Adult A. Such comments in context however are likely to refer to more latter events within the relationship.

5.12 The NHS CD and D IMR indicates that on the 2nd April 2003, Adult A had contacted her GP practice by telephone stating that she had been *'beaten up'* by her partner and that she did not wish to leave the house due to the bruising. The GP's documented advice was that she should attend accident and emergency, however the GP made a repeat prescription without seeing her. The GP's record also indicates that Adult A attended Casualty at A & E the following day, April 3rd 2003 for a 'soft tissue injury' to her face. However the actual records for the attendance at the hospital from the NTHFT cannot be found and consequently the extent of the injury, circumstances and any other information cannot be qualified. It is a fair assumption that the two reports are connected by their very nature and timing.

5.13 Some 9 months later on the 26th April 2003 a second domestic abuse incident is recorded by the Durham Constabulary. On this occasion they received a third party report that Adult A had been '*thrown down the stairs'* by Adult B. On attending the police officers discovered Adult A at the bottom of the stairs however they were then provided with a subtlety different version by Adult A in that she now claimed that she *had fallen down* the stairs accidentally following a verbal altercation with her husband. Both Adult A and B, who was also present, were reported as being drunk. Both had signs of minor injuries and although an ambulance attended Adult A refused further treatment following an initial assessment made of her by the paramedics.

5.14 It is of note that the attending police officer took exception to the circumstances as recounted by Adult A and the information that was obtained and consequently provided a separate written note to the domestic violence officer that outlined some additional concerns suggesting that the victim displayed '*classic symptoms of emotional abuse'*. In essence the officer did not believe what was actually being claimed by the victim as being an accident. Additionally the officers were informed by 'a friend' of Adult A (who is not identified) that this was far from an isolated incident. Adult A would not make any formal written statement but she was provided with a contact appointment with the domestic violence officer for the following day. Interestingly and with this additional information available the officer chose not to place Adult A as a perceived high risk or make an arrest of Adult B. Both however could have been the case given the circumstances and indeed the officers perceptions which were well founded. In addition there was no record of the children on the assessment and as a consequence there was no referral made to the Social Services., the policy at the time was however to only action a referral to social services when they were present or witnessed the violence. The police did identify within their assessment that Adult A was now a 'repeat victim' and was consequently in a position to receive additional or enhanced support, although it is not clear what this additional support would have consisted of at that time.

5.15 It also appears that the contact appointment with the domestic violence officer and Adult A did not take place and as a consequence the officer reverted to making contact by a formal letter which was sent via a third party[16]. What is apparent from this incident however is that there were opportunities for a more incisive follow-up given the additional information

[16] In order to remain as confidential to the victim, this is good practise as it offers alternative and confidential opportunities not likely to compromise the victim to the perpetrator.

that was available to the domestic violence officers. However taking this into context the police IMR indicates that at that time the volume of referrals was disproportionate to the numbers of DVO staff and as such many individual cases could only receive appropriate signposting to services. There was no expectation at that time that there would be contact with the victim by the DVO police officers. There were no arrests made in connection with this incident and it appears that offers of support were declined by Adult A, although again it is not clear what the extent of the support available actually was.

5.16 In evaluating this incident there are no referrals made to other agencies in connection with this occurrence. Taking this event on face value the allegation made is of an assault, the consequences of which could have been significant given the alleged circumstances of having been thrown down a staircase. At the time of the incident Adults E and F would have been 11 and 8 respectively and their presence in the household was not recognised as their details were missed off the initial report. It must be accepted that this was an error and given that the incident was alcohol related, there were potential safeguarding issues overlooked, coupled with a lack of other agency referral, in particular to Social Services. Whilst it is not uncommon for gaps to be made within reporting, it is imperative that all officers don't simply focus to the actual events but have a much broader perspective on the signs and symptoms or valuable information may be disregarded when such relevancy has a much greater potential impact. Gaps in this case seem to mirror those of the first reported incident. It is noted that at the time Durham Constabulary had a policy that they only referred on safeguarding concerns if a child actually witnessed the violence. This practice positively changed from 2005. Consideration has been given to the actions of professionals and agencies in this case; for example how the police in the early period of the timescales set for the review and carried out their risk assessment process in dealing with domestic violence. However as referenced above the police carried out their duties as was the guidance at the time and practice changed positively from 2005. This DHR is to learn lessons for the future and it is felt by the author and the panel that the police role and their current use of risk assessments has already made a positive contribution to prevention management of Domestic Violence in the Durham Police area.

5.17 In respect of the incident of the 26th April 2003, there are no other relevant matters raised or cross referred within the other agencies IMRs and as such this incident appears to have been treated in isolation. Neither Adult A nor Adult B appears to have sought any medical examination or advice following on from this incident.

5.18 Some 3 months later on the 31st August 2003, a third domestic abuse incident was reported on this occasion by a third party indicating that there was a domestic incident at the home of Adults A and B. This matter was reported shortly after midnight and appears to have been a continuation of an early incident late on the evening of August 30th between Adults A and B that had occurred outside of the local rugby club whereby both had 'struggled' with each other following an argument and as a consequence Adult A had suffered injuries from a subsequent fall. When Adult A had returned home later and separately from Adult B, she discovered that she had been locked out of the house and she was unable to gain access. When the police officers attended it transpired that they had found it necessary to force an entry into the house. Having taken this step they found Adult B asleep in bed. He was intoxicated and the officers then arrested him for the alleged earlier assault that had occurred outside of the club following the verbal allegation made by Adult A.

5.19 However although clearly making a complaint of assault, Adult A then declined to support any further investigation by the police and refused to make a formal written statement, other than that was made in order to provide the officers with the power to arrest. Consequently Adult B was later released from police custody without any further action taken against him. There is no indication that he was interviewed. The police records indicate that Adult A was written to by the domestic violence officer, although there was no record of any response from her. It is of note that this is the third incident whereby the response to the incident by the domestic violence officers was to make written contact. Whilst the review again acknowledges that this is a tactical option and may be designed to provide direct contact to a victim without engaging the suspect, it also prevents personal contact that could assist in information gathering even if the victim declines to support a prosecution. This being the third time that such a tactic was used, it is clear that by now a more direct approach could have been made, however it is fully understood that this was in fact over and above what was policy and practice at the time.

5.20 In evaluating the information provided within the IMR by the police there was again no acknowledgement of children within the household or whether or not they were present in the household at the time. Consequently there was no referral made to the Social Services.[17]

5.21 In evaluating the interaction with other agencies, there are no links apparent and in examining the other IMRs, Adult A does not appear to have sought any medical examination in respect of the injuries reported as being to her elbow and forehead.[18]

5.22 In February 2004, Adult A attended her GP practice reporting '*severe depression and alcohol problems*'. She disclosed that she was consuming in the region of a bottle of vodka a night and it was noted that her *"partner buys it for her"*. Adult A was referred to a local substance misuse initiative however she failed to attend and also failed to return to see her GP in a month as advised at the time of referral.

5.23 The next reported incident of domestic violence recorded by the police, was an incident that occurred on the 24th April 2004. The limited details obtained by the call taker originated from a very distressed female who stated that she had been beaten up by her boyfriend. On attending as immediate response officers spoke to the alleged victim and caller who was identified as being Adult A and although Adult B was present in the house and he was intoxicated, he was calm and had no apparent injuries. Adult A complained of having been repeatedly kicked by Adult B and having had large lumps of her hair pulled out during the incident.[19]

5.24 The police arrested Adult B for the assault and importantly on this occasion he received a formal police caution for the offence as a common assault (Battery, section 39 Criminal Justice Act 1988)[20] The most important factor herein is to recognise that in order to

[17] In 2005 the force domestic violence policy was amended in agreement with partner agencies that where children were involved and not just witnesses to domestic abuse, that Social Services were notified accordingly.

[18] It is an accepted practise that police officers are able to provide evidence of apparent injuries and this can also been enhanced by photographic and where available 'headcam' footage.

[19] This level / type of assault appear to be a frequent occurrence as referred to by Adult A's close relatives in their responses to the review.

[20] A person commits an assault if he does an act (which does not for this purpose include a mere omission to act) by which he intentionally or recklessly causes another person to apprehend immediate unlawful violence.

receive a caution that notwithstanding that there is evidence of an offence that both the offender must admit to the alleged act and the victim should agree to this course of action being taken. What is not clear from the police IMR as people are unable to recollect due to the passage of time is to the extent of the admission by Adult B and whether or not the file was referred to the Crown Prosecution Service under any protocols that existed at that time. This caution is a recordable offence for the purpose of inclusion within the criminal record of the offender, although importantly citing such a record is dependent upon other criteria being fulfilled. This does have future relevancy in examining the facts within this overview concerning Adult B's acquisition of firearms. The Social Services was notified of the incident within 72 hours of the occurrence and both children were listed on the domestic violence referral form. The IMR author has tried but cannot clarify if the children were present at the time of the incident. The victim was identified and assessed as having a perceived high level of risk. Records from the police also indicate that a referral was made to Durham County Council on the 4th May 2004 although the extent of that referral is not apparent.

5.25 The NTHFT records indicate that Adult A attended accident and emergency at Hartlepool on the 27th April 2004 (GP records actually incorrectly indicate 27th March 2004) with a soft tissue injury to her chest. The record indicates that this was as a result of an assault two days previously although there is no indication as to who was responsible but that the victim was *'punched left side of chest'*. Although this visit accords with the incident above, this is some 3 days later and again the possibility of a further or further incidents occurring in the interim cannot be ruled out. The notes from the hospital also indicate that Adult A received 'domestic violence information'. It was noted by the NTHFT IMR author that there was no recognition of the children and *'no documentation to support further assessment around the history of abuse between Adult A and the alleged perpetrator'.* This again exemplifies that the focus was to dealing with the injury as opposed to ensuring that the wider picture received appropriate consideration. The NTHFT are not in a unique position here.

5.26 The NTHFT IMR indicates that *'no due consideration had been given to any related children's safeguarding concerns'.* This again shows that no single agency can be held responsible by such omission but that it is important that each agency looks wider than just the facts as they are reported on every occasion. Individuals must be curious and inquisitive.

5.27 The next reported incident that was made to the police occurs in excess of 4 years later and is reported on the 10th September 2008. The overview has considered and evaluated the issues within that interim period featured within the knowledge of other agencies, but not that of the police. It is this focus where the matter of the application by Adult B for a shotgun and later firearms certificates is of relevancy, particularly in so far as the police records are concerned, as it is an irrefutable fact that Adult B became the holder of a registered shotgun that was used to kill Adult A, Adult C and Adult D.[21]

5.28 It is a recognised fact that Adult B made an application for the grant of a shotgun certificate to Durham Constabulary on October 10th 2006. This application was granted on the 7th February 2007.

[21] The overview acknowledges that any conclusion as to the cause of death and verdicts remain as the duty of the HM Coroner to determine at formal inquest. The overview makes the assumption based upon information provided that Adult B is the only suspect in the deaths of the other deceased adults in the absence of any other information or evidence.

5.29 It is a fact that Adult B made an application for the grant of a firearms licence to Durham Constabulary on the 7th February 2008. This application was granted in May 2008 although the actual date cannot be qualified by the overview process.

5.30 Between the domestic abuse incident reported in April 2004 and the incident reported on the 10th September 2008 to the police, a total of some 4 years and 5 months had elapsed according to the Police IMR. The other agencies references to the subjects in that period are in summary recorded as being as follows:

5.31 On the 1st September 2004, Adult A attended accident and emergency with pain her left foot. The records indicate that she had woken up with the pain and that no history of the injury was given.

5.32 On the 7th February 2005, Adult A attended her GP and reported that she was still drinking *'over one bottle of vodka a night'*, was still suffering with depression and had *'issues of DV and husband having an affair'(sic).* A further referral was made to the substance misuse service and it was also noted that she specifically wished for the support of a female counsellor and to be seen at home when the children were not present. However despite these requests she did not attend the misuse service and was discharged on the 31st March 2005. The overview notes that the seeking of services and disclosures made by Adult A were made in what appears to be a 'cry for support'. In this case the failure to engage further by Adult A was at the core of the closure without any additional follow up to her by any of the agencies.

5.33 On the 16th February 2005, Adult B attended the accident and emergency department of a local hospital with a knee injury which had apparently occurred whilst playing football. No additional information exists as to the full extent of or the treatment for the injury.

5.34 On the 23rd May 2005, Adult A attended hospital at the accident and emergency of a local hospital from a fall *'15 days previously'* suffering from a painful right elbow. No circumstances are recorded according to the IMR from the NTHFT other than that the injury was as a result of falling on the elbow. Consequently no information can be established as to the causation or facts as to the circumstances. No additional information is available from GP records. The significance of this apparent late reporting cannot be established.

5.35 The NTHFT IMR also identifies that Adult A attended at an accident and emergency department (within the reporting period) on 9 separate occasions that were related to her suffering from 'abdominal pain'. It is also accepted as a fact by the review that Adult A had an on-going gastritis related medical condition for which she had received treatment both as an in-patient and outpatient over a period of several years. It is of note that the IMR acknowledges that during these numerous admissions for the complaint, some of which were by ambulance, that the assessments made referenced alcohol consumption on most of the medical records. It is noted that such admissions of the actual consumption made by Adult A varied in respect of the quantities on each occasion. It is also identified that one incident made reference to the psychological effects to Adult A within the occurrences. The overview makes a reasonable conclusion that this incident should be regarded as unrelated to the alleged violence, but is nevertheless relevant to the disclosures concerning alcohol consumption on the part of Adult A.

5.36 It is noted that from GP records, there was limited contact with Adult A for the remainder of 2005 although she was seen by a locum in September 2006 in respect of a 'minor health condition' the details of which are unrelated to this DHR.

5.37 Adult B is recorded as having attended his GP practice on 9 separate occasions within the reporting period. Between 2002 and 2005 he was reported as not having seen a GP at all. On the 19th July 2006 and the 3rd April 2007, he was seen on both occasions for whiplash injuries which were consistent with minor injuries sustained in road traffic collisions, which would appear to have been on different occasions. There is no reference within the police records to reports of road traffic incidents relating to adult B which suggest that they may possibly have gone un-reported, although it is a fact that he was a taxi driver at that time which may have some significance but is not explored further in this overview due to the lack of information.

5.38 The GP practice record concerning the visit by Adult B on the 3rd April 2007 indicates that the whiplash injury was sustained a month previously and that he *'does a lot of shooting which causes him pain'*. At this time he would have been the lawful holder of a shotgun certificate albeit of just some 2 months duration, although it is acknowledged that he was a member of a local shooting club.

5.39 It is perhaps appropriate at this point to clarify that in order to acquire (by purchase or loan) a shotgun the holder must produce his or her certificate in order to enable this transaction to take place. The police are able to place conditions on the holder of shotguns or firearms and have the powers to remove and withdraw the certificates in certain circumstances.[22]

5.40 On the 19th June 2007, Adult A attended her GP practice and saw a practice nurse. Adult A indicated that she had been assaulted 3 days previously. Her injuries were noted as being bruising to face and hair loss. The notes indicate *'Multiple patches of traumatic hair loss to scalp, bruising to left eye and cheek. Police involved.'* There is however no record of any involvement by the police nor is there any clarity to the practice nurse as to who was alleged to have assaulted her. This is nevertheless a key incident given that this allegation of assault occurred just 4 months after Adult B had been granted a shotgun certificate (and it is a presumption that weapons had been acquired by that time) The GP practices for Adult's A & B were different at the time and Adult B's GP would be unaware of this incident, and equally Adult A's GP would be unaware that Adult B held a gun licence.

5.41 2 days later on the 21st June 2007, Adult A was seen by a GP from her practice and on this occasion the relevant notes indicate that she is having *'relationship problems'* and further that she was assaulted by her *'partners aunt'*. Adult A was issued with a sick note for her employer as she was not sleeping and was unable to face work. This would appear to relate to the reason for the above described visit to the practice nurse on the 19th of June 2007.

5.42 Four months later on the 18th October 2007, Adult A attended her GP practice and reported that she had fallen down the stairs four days previously and had injured her back. She made no allegations concerning this injury and was referred for x-ray, but failed to attend. The fall was described as being from 'top to bottom'.

[22] The review does not intend to duplicate the review being made by the IPCC in this respect.

5.43 The overview report continues to acknowledge the attendance of Adult A to accident and emergency at local hospitals in connection with the on-going abdominal pains over the review period as previously indicated.

5.44 On the 27th January 2008 the police attended an incident at a local club and discovered an unidentified man who had sustained a facial injury and had blood stains on his shirt. This man refused to speak or to identify himself to the attending officers and as he walked away Adult B was observed to step forward and strike the man in the face causing him to fall to the floor. Despite this the man however continued to refuse all details or to make any complaint concerning the assault by Adult B. It is apparent that although the attending officers were interviewed by the police IMR author, that they cannot recall the incident, although the report of the incident indicates that Adult B was actually seen by officers to commit this assault (there can be no doubt that this constitutes an assault) and that he was arrested for an affray[23]. Adult B was apparently released without charge the following day with no further action following advice sought from the Crown Prosecution Service, claiming that this was in fact an act of self-defence. What is critical to assess at this point is that this is an incident that is apart from the domestic violence issues, but moreover it is in a public place, involves the public peace and is an indication of the apparent loss of control of Adult B. Alcohol would again appear to have significant bearing in this instance. However it is apparent that the decision not to prosecute was taken out of the hands of the police. Adult B was at this time the holder of an authorised shotgun certificate. His weapons were not seized as a consequence of his arrest.

5.45 Less than two weeks later, on February 7th 2008, Adult B, as the holder of a shotgun certificate and associated weapons, made an application for the grant of a firearms licence. This was granted in May 2008. The incident at the club was a matter of relevancy to such an application, even though there was no formal action taken against him.

5.46 Between the 23rd May 2008 and the 20th August 2008, Adult A attended accident and emergency in connection with abdominal related pain and this culminated in gall bladder surgery.

5.47 On the 6th September 2008, both Adult E and Adult F attended the Peterlee Urgent Care Centre with ear ache and exacerbation of asthma respectively.

5.48 The police IMR refers to an incident of domestic abuse that occurred on the 10th September 2008 involving Adults A and B and other family members. This incident took place late in the evening and occurred during a party for the celebration of the 14th birthday of Adult F. The record indicates that there are two contact calls to the police reporting the incident, the first of which is from a sibling of Adult A stating that she had been assaulted by Adult A. The second call made four minutes later by Adult A herself, reports that she has had an altercation with her sister and that her own partner (Adult B) who has a gun licence, had threatened to shoot himself. It transpires that Adult B had actually threatened to *'blow his own head off'*. Adult F had been present and appears to have witnessed [to an unknown extent] the events and as a consequence took possession of or removed the key to the firearms cabinet and had run away to his paternal grand-parents home. Adult A was advised

[23] Public Order Act 1986, Section 3. A person is guilty of affray if he uses or threatens unlawful violence towards another and his conduct is such as would cause a person of reasonable firmness present at the scene to fear for his personal safety.

by the police operator to leave the home immediately and to take any children present with her. It appears in contextualising this incident that Adult A was the catalyst to the events.

5.49 The response from the police accorded with a firearms related incident response and consequently experienced and armed firearms response officers attended for safety both of themselves and the wider public interest. The officers discovered Adult B in bed, intoxicated and that all the weapons held at that time, actually remained securely locked within the secure gun cabinet in the house[24]. However the officers nevertheless seized the weapons in order to maintain both individual and public safety[25]. Adult B denied making any threats and he was compliant to the officers. He was arrested in order to prevent a further breach of the peace. There is no information to establish what action if any was taken in respect of the allegations by Adult A against her sister or vice versa.

5.50 The police control room incident acknowledged the seizure of the weapons and in accordance with practice the firearms licensing department were notified accordingly by e mail within an hour of the incident. It is also important that not just the weapons are seized but also the shotgun certificate and firearms licence are also seized as this would ensure that the holder was no longer able to (lawfully) purchase or acquire weapons. It appears that only the firearms licence was seized but not the shotgun certificate, this should always occur although the key action is to secure the relevant firearms and ammunition at the time and any follow up action should be undertaken by the licensing department. The overview process identifies that this initial action by the police was good practice as per ACPO Guidance and a timely intervention, however the subsequent follow-up by the firearms licencing department was not incisive in verifying that all necessary action had been taken. This is an issue that the IPCC and the internal police investigation have addressed

5.51 By this date there had been a significant change by the Durham Constabulary in the procedure for dealing with incidents of domestic abuse in line with national improvements in reporting processes and assessment of the victims. This level of risk assessment provided a more in depth analysis of the victim and events. It is apparent that this process now included a more in depth series of questions and a risk assessment requiring the officer to indicate if they considered the victim to be at a high risk of experiencing imminent further abuse. On this occasion however the reporting officer did not provide any indication as to the perceived risk as the relevant document field was not ticked. Two responses that were ticked accordingly were *'does the offender have any aggravating problems?'* this response indicated alcohol as the problem and *'Has the offender attempted/threatened suicide?'* The indication was clear in that the threat by Adult B was made that he had threatened to shoot himself.

5.52 The domestic violence officer (DVO) graded the risk to Adult A as being medium, following a review of the information provided and consequently appropriate referrals were made by the police to Social Services in respect of Adult E and Adult F as they were both under 18 years of age at that time.

5.53 The IMR indicates that Adult A "*still refused referrals to support agencies*"; however it is not clear what contact was made with her by the domestic violence officer. What is of

[24] Generally a condition of the respective licence/firearms legislation.

[25] Each case would be treated on its own merits, but such action would generally be taken under the circumstances and is good practise.

significant concern is that although the welfare of the [then] children was considered, and a screening process took place within social services this does not appear to have included any more intensive intervention by experienced child protection staff. Also of significant concern is the fact that Adult F was known to have taken the key for the firearms cabinet, the overview assumes that he either knew where the key was held or undertook to obtain it of his own volition. It is surprising to note that at no time was either Adult F or Adult E engaged with by the police or Social Services in respect of this particular occurrence.

5.54 The police IMR states that *"In all 5 cases the actions taken by response officers and domestic abuse officers were in line with the force policy and procedures that were available at that time"* and adds that Adult B was arrested in four out of the five incidents. Adult B was only proceeded against in one of the instances, which was that of the 24th April 2004 and was by way of a formal [police] caution. In the remaining cases it appears that Adult A was not supportive of any investigations into the conduct of the incidents. Whilst this makes prosecution difficult, it does not prevent an intelligence perspective of the victim, perpetrator and the circumstances surrounding the incident. What is of note is that of the incidents there does not appear to have been any incisive intervention by the police and partnerships into any single occurrence although the overview acknowledges that the police did take initial action in line with best practice and procedure on each respective occurrence by appropriate interventions which were in use at that time.

5.55 On the 24th November 2008, Adult B's firearms were returned to him accompanied by a letter 'in the sternest of warnings' advising him of his future conduct where the revocation of his respective authorities would be withdrawn.

5.56 Between the 21st September 2008 and the 2nd April 2009, Adult A attended hospital on three separate occasions concerning her continued medical condition that was associated with abdominal pain. On the 11th February 2009 during an admission to hospital a note is made of what appears to be her continued reliance upon alcohol by her own admission to her level of consumption at that time.

5.57 It is noted that both Adult E and Adult F attended their GP, walk in centre or hospital on a number of occasions none of which are of particular note or are considered as being associated directly to domestic abuse.

5.58 On the 31st December 2010 Adult B attended his GP Practice where tests identified an abnormal liver function. Adult B denied excess alcohol use during his examination in this instance.

5.59 On the 22nd February 2011 Adult A visited her GP Practice and the notes indicate that *'her partner left her unexpectedly 1 week ago'.*

5.60 On the 3rd March 2011, Adult B attended his GP Practice and it was noted that his ultrasound scan result revealed early signs of liver degeneration and that he was consequently advised to reduce his alcohol consumption. Two weeks later he attended for an out-patient appointment at NTHFT where the notes indicate that he was living at home with his partner and 2 children. It transpired that he had actually suffered a minor heart attack.

5.61 On the 6th April 2011, Adult A made an application to Durham County Council Housing Solutions to be re-housed due to a marital breakdown and that the family home was ready to be sold. The application indicates that she stated *'husband drinks a lot and is starting to be violent towards daughter'.* However the application made by her remained open although there was no further contact from Adult A in this respect with Housing Solutions who at this point were part of the Local authority. The application was never closed and remained open with the local authority until the death of the applicant was notified to them.

5.62 On the 17th May 2011, Adult A attended an Urgent Care Centre, in the only contact details had with her by the CDDFT, following an alleged assault on her by her partner that same evening. The record indicates that she was quite distressed, having left her teenage son alone in the house and was worried that her partner would return. The actual injury alleged comprised of pain in her left upper arm and left thigh from having them twisted up her back. The subsequent examination actually revealed no bruising or swelling although there was a small abrasion on her upper back. She also smelled of alcohol. It appears that she declined a full medical assessment and also refused the offer of police involvement or referral and she left the urgent care centre after little over an hour. She did not return despite being advised to make a follow-up visit by the centre staff the next day.

5.63 On the 1st June 2011 Adult B attended the Rapid Access Chest Clinic where the assessment made refers to his high blood pressure and that he had suffered a [previous] minor heart attack. Again the excessive intake of alcohol is apparent. A further incident where Adult B encounters chest pains is recorded on the 26th September 2011 and he is treated by a paramedic, refusing to attend hospital. Reference is made to the fitting of stents 10 weeks previously although from the information presented by the IMRs this surgery cannot be clarified as to having actually taken place.

5.64 On the 7th September 2011, Adult A was taken by ambulance to hospital, hyperventilating and was described as having been drinking. The root of this appeared to be abdominal pains.

5.65 There are no other references made to contact by any of the relevant agencies with any of the referenced adults from September 26th 2011 up until the relevant incident in January 2012.

5.66 The overview does not intend to rehearse the incident in January 2012 other than by reference to the incident as being the key incident leading to the reporting of this DHR.

5.67 The overview also acknowledges that the HM Coroner has primacy in the investigations into the deaths of the respective victims.

6.0 Analysis

6.1 It is important that agencies that are required to do so, undertake an internal management review immediately following a domestic violence homicide, so that learning can inform changes to policy and practice at the earliest opportunity. In this case the panel chair and the overview author feel that even though delays in the preparation of some of the IMRs are understandable given parallel processes, and the need to obtain consent, that the

draft IMRs should have been completed quicker. The overview author acknowledges that each of the IMRs adequately addresses the terms of reference.[26]

6.2 There is an absence within the DHR of any active social services investigation, although there was screening following two referrals concerning the children, this created little if any inter-agency dialogue. It is worthy to note however here the context statement at 4.11 that the management of referrals at this time was managed elsewhere in the council than within children's services. What is of concern is that despite the fact that Adult A declined or failed to engage with police officers in respect of the allegations of domestic violence, that there needed to be as much emphasis on the welfare considerations of the children as there did to the abusive relationship. The significant question that needs to be addressed here is, were the children adequately protected at *all times* and was their perspective taken into consideration when the background enquiries were made into the suitability of Adult B to acquire both shotguns and firearms respectively. The overview process cannot establish that this was the case as there is not a clear indication as to what involvement by the forces child protection unit there actually was and how this does or perhaps should link into the firearms licensing department. Whilst this is specifically a matter for consideration by the IPCC investigation, the overview can find little evidence or information that this was a consideration which was of equitable concern as the domestic abuse. The recommendations from the IPCC and Durham Constabularies firearms licencing review do adequately address this point for learning lessons and already changing current practice.

6.3 To analyse this safeguarding function further, it is also a reasonable assessment that other agencies have also failed to consider child welfare and the overall lack of safeguarding considerations left a significant hiatus in ensuring joined up activity and information sharing was at the heart of overall safety considerations. This is both to the individuals and also to the wider public interest.

6.4 The CDDFT IMR identifies that *" A full and complete picture does not emerge from the report about what it was like [for Adult E or Adult F] The main focus of activity was on the physical injuries sustained [to Adult A] following the alleged assault by her partner"*. The overview acknowledge this as a key issue, however this was a single occurrence by that agency, where others have repeatedly made the same omission. This becomes a key learning point for all agencies.

6.5 In examining the details of the respective IMRs the apparent excessive alcohol consumption that was admitted on the parts of both Adult A and Adult B on a number of separate occasions appears to have had a significant bearing upon the prevalence of domestic abuse and domestic violence. This amplifies the concerns for the children who were exposed to this parental alcohol misuse by both Adults A and B.[27]

6.6 The presence of domestic violence is apparent on numerous occasions over and above the number of incidents that were reported to the police. From the analysis that the overview author has completed, he believes that there are at least 17 incidents of domestic abuse

[26] The overview author will provide direct feedback to the Newcastle College for future reference in consultation with the Chair of the CSP.

[27] Silent Voices – A report into parental alcohol misuse by the office of the Children's Commissioner, September 2012. http://www.childrenscommissioner.gov.uk/content/publications/content

between Adult and Adult B, including the five incidents that were reported to the police. It is accepted by the overview in commentary that much of the history was concealed within the household and although probably known to friends and family, it was not revealed to any significant extent outside of this close circle and was certainly not reported to the police by third parties.[28] It is important to note that as well as physical abuse that occurred within the household of Adults A & B that emotional and psychological abuse may have also occurred. This is described as *'Emotional or psychological abuse can be verbal or nonverbal. Its aim is to chip away at the confidence and independence of victims with the intention of making her compliant and limiting her ability to leave. Emotional abuse includes verbal abuse such as yelling, name-calling, blaming and shaming. Isolation, intimidation, threats of violence and controlling behaviour[29]'*

Many abused women define the psychological effects of domestic abuse as having a 'more profound effect on their lives- even where there have been life-threatening or disabling physical violence. Despite this, there is almost always pressure to define domestic abuse in terms of actual or threatened, physical violence.

6.7 Had such information been made known to the police and other agencies it is a reasonable conclusion to reach that a more robust picture would have emerged in particular concerning the alcohol abuse by Adult B. This is a significant matter when considering what picture could have emerged in particular about Adult B when information concerning his background was essential in evaluating his suitability to acquire and possess the respective firearms.

6.8 The police IMR state at 10.15 that *"It is clear that friends and family members knew that Adult A was in an abusive and violent relationship. However whilst they knew of the violence Adult A suffered, they did not report it. This is understandable, at the time of the abuse and even today there is little opportunity for the confidential reporting of domestic violence by members of the public"* The overview does support this rationale, however community intelligence is frequently a good source of information. However capturing such information from the community could add an additional dimension. The action plan (1) recommended by the force is however an innovative opportunity to explore partnership opportunities to advance a pro-active intelligence perspective and the overview would recommend that the force also broadens this perspective by examining innovations across other police forces to capture information that is capable of being shared within existing partnerships.

6.9 The overview also wishes to acknowledge that the systems and processes under the policy for dealing with domestic abuse has changed significantly over the reporting period of this review and that the Durham Constabulary now has a central referral unit[30] which is able to make quick time and informed analysis of domestic abuse related incidents. In order to ensure the continued effectiveness of such multi-disciplined teams the integration of agencies will only continue to enhance the service to victims and the overview would endorse the perspective that the composition of the unit is supported by a health partnership at the earliest opportunity.

[28] An overall recommendation is made concerning observations made within the respective IMR's.

[29] http://www.domesticviolencelondon.nhs.uk/1-what-is-domestic-violence-/3-emotional-or-psychological-abuse.html

[30] A significant number of police forces within England and Wales have integrated other agencies in joint working environments and such 'partnership' approaches are having a profound effect on the immediacy of responding to safeguarding in a multi-disciplined environment and in the wider context of overall safeguarding provisions for adults, children and the vulnerable.

6.10 In examining the actual incidents of domestic abuse in this case, just 5 instances were reported to the police. These incidents are the key considerations in looking at the later firearms issues, but taking other agencies IMRs into account, this was far from the bigger picture of what life was actually like within the family environment.

6.11 A significant number of instances have been recorded by other agencies within the health service where there has been no police involvement. In these instances, the lack of knowledge by the police who did not request other agency information placed them at an immediate disadvantage in particular when it came to examining the issues relevant to the grant of firearms. It is Important to note here as well that Adults A & B did have different GPs. The Bichard Inquiry in 2004 identified the lack of information sharing between police forces however there is no recognised current national process that allows sharing of (for example) medical records which are generally regarded as being confidential between the adult patient and their healthcare provider, had there been this should have triggered a greater level of information sharing than is the case here.

6.12 The basic analysis which is at the heart of the fundamental issues in this case concerns the lack of inter-agency (and intra-agency) communication, where a more informed picture of the household could have been ascertained. This in itself would have been a key factor in the Durham Constabulary's ability to have presented a robust case against Adult B's possible acquisition of both shotguns and firearms. However it is also acknowledged by the review that of the 5 reported instances of domestic violence, the force has not provided any evidence, other than immediate and preventative intervention, that there was an intended intervention in the longer term in any of the instances.

6.13 In addition to the issues surrounding domestic abuse and alcohol abuse, mental health is also worthy of note arising from, in particular, the fact that Adult A was on medication for depression and anxiety as early as 2001 when it was noted in the GP records that 'relationship problems' existed. This was a 'toxic trio' but has not received any direct acknowledgement by any single agency.[31]

6.14 Another question to ask is what was life like within the household, not just for Adults A and B but also the children, Adults E and F. The Head of Education in Durham authorised a check of school records for the primary and secondary schools that Adults E & F attended and nothing was found of relevance to the overview report. As nothing was found there is no report or link to education and the overview process questions if the education institutions of Adults E and F could offer any insight into the family that has been overlooked and could also add a dimension to the overall family picture. The facts given to the overview author is that there was none, however looking at the history as known, it would be unusual that there were not indicators or triggers that could have provided some dialogue opportunities, with multi-agency safeguarding partners.

6.15 The family suggest that Adult A doted on both of the children and had considerable interaction with them. The overview process can show no evidence to the contrary. It is perhaps reasonable to assume that Adult A took them to and from school on occasions. Certainly in early 2001 to a similar time in 2002, she was suffering from depression and

[31] The term 'Toxic Trio' has been used to describe the issues of domestic violence, mental ill-health and substance misuse which have been identified as common features of families where harm to children has occurred. They are viewed as indicators of increased risk of harm to children and young people.

although it could be possible, it is hard to believe that this had not been observed by a third party or indeed had some effect on the children within the educational environment. Schools and the staff within them play an important role in safeguarding their children. Had they been alerted by the authorities to the concerns and needs within this family they could have offered additional support to Adults E and F, when they were pupils in their respective schools.

The Police

6.16 Analysis of the firearms. The overview acknowledges the concerns voiced by a number of the family members regarding the acquisition of the firearms and shotguns by Adult B. Clearly this a particularly emotive subject and the overview report must acknowledge at this point that the issues concerning law, policy and procedure are of particular significance to the independent report by the IPCC. Similarly, the IPCC may make specific recommendations to the Durham Constabulary that have a national perspective. Whilst the overview report cannot speculate in this respect it has taken into account the comments raised by members of the family.

6.17 The overview author also acknowledges that there is a distinction between the granting of a shotgun certificate and the granting of a firearms licence. Home Office guidance sets out different tests for shotgun certificates and firearms licences. Equally, once granted particular conditions may be placed upon the holder that accord with the applicant's antecedents. Facts are of course of particular relevance when making background enquiries although the police should retain ultimate decision making which can be on the balance of probability. In order to refuse an application outright certain conditions have to be observed. The overview has not viewed any of the relevant material in respect of the firearms matters other than that with which is contained within the police IMR as well as the IPCC report and the Constabularies firearms licencing review recommendations.

6.18 The overview report is therefore cognisant that the police IMR has little detail concerning the matters pertaining to the firearms and is satisfied that this perspective has been dealt with independently by the IPCC. However, in view of the fact that the deaths of the victims and perpetrator was by the use of a licensed weapon, it has been reasonable to examine some of the key issues.

6.19 Adult B had a recorded police caution that was issued following the assault which occurred during the incident on the 24th April 2004. This was not a criminal conviction made in a court of law for which the accused was required to declare on his respective applications, although the police would have been aware of this incident arising from their background enquiries that are procedural at the point of application. This in itself would not render the refusal for the issuing of a certificate as a caution does not constitute a conviction, despite the view by a number of the family members that it should be. Cautions are recorded on the Police National Computer however declaration will be an individual applicant's decision.

6.20 Domestic abuse, mental health, criminal convictions and intelligence are examples of issues that should all be taken into account by the issuing authority, who by legislation is designated to be the Chief Constable of the Durham Constabulary. In reality this authority is generally delegated by the Chief Officer to a senior officer, usually of Chief Superintendent

or Superintendent Rank. The overview author also acknowledges that the designated officer will not as a matter of course view all applications but is likely to retain the ultimate decision making in the event of any question as to the suitability of the issuing of certificates and licences. This perspective is regarded as best practice across the majority of police forces. Invariably this perspective is supported by appropriate 'in-house' or outsourced legal advice.

6.21 It is a fact that Adult B was granted a shotgun certificate and acquired weapons in accordance with the conditions of that certificate from the 7th February 2007 and in May 2008 he was granted a firearms licence, again acquiring weapons in accordance with that licence.

6.22 The incident of the 27th January 2008 (the affray incident) pre-dates the application for the firearms certificate. It is noted that Adult B was arrested in respect of this incident, but no action was taken. This incident was one where violence associated to the consumption of alcohol that occurred in a public place appears to be at the root of the incident specifically on the part of Adult B. The overview process can find no information to suggest that there was any intervention on the part of the police to seize the weapons that were held by Adult B at that time in respect of his shotgun certificate. In overall terms this incident seems to have gone by relatively un-reported and it is questioned as to if this was just an oversight or a missed opportunity. The applicant was however sent a warning letter in connection with the incident during the conduct of the application for the firearms licence by the Durham Constabulary.

6.23 The incident that occurred on the 10th September 2008 was just 4 months after the granting of the firearms certificate to Adult B in May 2008. The police response to the incident was swift and incisive in that the weapons in the house were removed immediately following the arrest of Adult B. This incident was a clear indication of how a licensed firearms holder should not act and the serious considerations made by the police at that time. However the fact of the matter is that this incident should not have been treated in isolation, but should have led to a wholesale overview of the suitability of the holder to retain and maintain his authority to hold any of the firearms.

6.24 There was no formal revocation of the shotgun certificate or of the firearms licence of adult B, other than what appears to be a period following his arrest on September 10th 2008, where the weapons were tactically withdrawn from his actual possession. His certificate was never seized.

6.25 The decision to return the weapons was ultimately that of the Chief Constable of the Durham Constabulary, as indeed was the original granting of the respective licences. It is a fact that the weapon which was used to kill the victims and the perpetrator was held lawfully by Adult B. The question that remains to be answered however is was the process of the original granting of both the shotgun certificate and the firearms licence made in the best interests of the applicant, his family and the wider public.

6.26 The fact that the weapons were lawfully held and the circumstances that led up to the application and the subsequent return (irrespective of the facts that were unknown to the police) require to be fully examined. It is not for the overview report to comment as to the processes that the police undertook in the analysis other than to question, were the

processes sufficiently robust in law, policy and procedure to support the decision making in this case.

6.27 It is also important however to note that a period of in excess of 3 years had elapsed between the return of the firearms to Adult B and the tragic events of January 2012. However it must also be acknowledged that had Adult B not had such capability by his un-restricted access to the weapons that one or more of the deaths on that particular evening may possibly have been averted.

6.28 The overall police response to the domestic abuse incidents at the home of Adults A and B was on the face of the initial responses adequate and where some positive intervention took place, this was good, despite the reticence of Adult A to support any further investigation.

6.29 However acceding to the perspective of the victim is not an effective response to dealing with domestic abuse and the overview author considers that the responses made by the domestic violence officers although positive an in keeping with policies and procedures at the time lacked a thorough and pragmatic review. There is no evidence that the response was anything more than adhering to policy as opposed to a holistic analysis where alternative opportunities could have been explored. The overview author comments that the force has moved on considerably since the early occurrences in its approach to domestic abuse and that it doubts if such a repeat in practice would be likely to occur. That said, the force needs to ensure that both its efforts continue to be forward thinking along with the partnerships as this responsibility must be shared and any gaps in process are identified by an inter-agency approach.

6.30 Analysis of the IMR shows: Positive action by the Constabulary at the initial encounter is encouraged to all front line staff which should, as a consequence, lead to other positive intervention activity. The integration of professionals within a multi-disciplined environment like the central referral unit where the most vulnerable victims or potential victims are identified by robust assessment process can only enhance the initial positive intervention activity. Principally activity here is directed at safeguarding children, vulnerable adults and those experiencing domestic abuse. The changes to the response to firearms related incidents where the offender is a recognised holder of firearms or shotguns receives immediate senior management overview by the force control room. Safety of the public is a significant consideration. The notification process from this point is immediate flagging to the firearms licensing department. The domestic abuse assessment forms for front line staff are fit for purpose and up to date with national ACPO best practice. Durham Constabulary is promoting an awareness campaign for all front line officers concerning domestic abuse.

6.31 Research into the effects of domestic abuse, parental mental health issues and substance misuse, on children are well known and have been evidenced for a number of years. In a biennial analysis of serious case reviews into the deaths and serious injuries to 189 children it states; *"Nearly three quarters of the children lived with past or present domestic violence and/ or past or present parental mental ill health, and / or past or present parental substance misuse. "Marion Brandon et al 2009*[32]

[32] Brandon M et al, (2009) 'Understanding serious case reviews and their impact' 'A biennial analysis of serious case reviews 2005-07 DCSF

6.32 In the case of Adults E & F, the above parental characteristics were abundantly clear to all of the professionals that came into contact both with Adults A & B but also with themselves. The overview author is of the opinion in view of the fact that after the initial screening there were never any active children's social care interventions, more could have been done by a number of safeguarding professionals to safeguard their welfare, in particular when Adult A had injuries and said she had been assaulted by her partner.[33]

GP Practice (NHS CDD) on behalf of Primary Care.

6.33 As previously stated the IMR for NHS County Durham and Darlington is of a particularly high standard, and the analysis of the GP's involvement with Adult A is particularly robust. For example at 4.1.8 of the IMR it states: *PN also stated that "if the patient had not reported it to the Police she would encourage the patient to do so and if there were children involved she would have made a safeguarding referral".* Despite stressing what they "would have done" it is not possible to establish whether PN or GP2 did in fact take any action as neither of them was able to recall Adult A as a patient and there is no record made of any action taken. In the author's view by documenting 'Police involvement' without any further clarification about actions taken, or not taken as the case may be, suggests that the health professionals were abdicating themselves of responsibility in terms of the victim's safety and specialist support needs by making the presumption that these issues had or were being been dealt with by the police. DoH guidance (2000) states *"It is not acceptable to simply assume that someone else - such as social services or the police - will be doing something".*

6.34 The Home Office in its guidance for health professionals suggests that given the importance of domestic violence as a factor impacting on health, training about enquiry should be part of pre-registration curricula and post registration on-the-job training for all health care professionals (Taket, 2004) [34].

6.35 In the overview author's opinion there were a number of areas within which the GP's practice surgery for Adult A should have been more proactive in their safeguarding of her and also the children, Adult's E & F. For example:

a) As mentioned at 6.33 above the acceptance that someone else was doing something to safeguard, as in this particular incident's case they were not. This was at it turns out appear to be a completely different and separate incident.

b) At no time did they make a referral to children's social care to safeguard the children, in particular when they were dealing with Adult A for mental health issues, domestic abuse and alcohol all of which were referenced on a significant number of the visits.

c) When the hospitals sent them information concerning the treatment of her, it transpires that they never spoke to Adult A about the reason she had gone to hospital even as and when the information referred to domestic abuse.

[33] Working Together 2010.

[34] Should Health Professionals Screen All Women for Domestic Violence? Ann Taket, C. Nadine Wathen, Harriet MacMillan 2004

6.36 General Practice is invariably the main point of contact for all primary healthcare services. It can be expected that General Practitioners will have a holistic overview of their patients and their needs. However, General Practice has changed significantly in more recent years. The traditional practice where one or two practitioners know all their patients, and their extended families, is rapidly disappearing. Moves towards larger practices with part-time and/or salaried clinicians and a range of service providers such as walk in centres and contracted out of hour's services, impact upon the locally held community knowledge base of patients and consequently continuity of care. It is therefore critical that communication and record-keeping is robust and meticulous.

6.37 It is apparent that in this case that although records of the attendance of Adults A and B at other healthcare locations were communicated to the respective GP Practice, on occasions the records concerning the actual details of the visits were limited in content but equally may not have been fully interrogated when received and integrated into the respective patient records. It is fully accepted by the overview author the problems caused for health practitioners relating to the different and incompatible IT systems that are in operation, for example between the GP practice's for Adult A and the one for Adult B they both have different IT systems, an added further concern is that neither GP surgery would routinely share information.

6.38 The Royal College of General Practitioners (RCGP) has produced guidance for GPs: 'Domestic Violence: The Role of the GP'. This guidance aims to raise awareness of this issue amongst GP's and encourages GP's to be proactive in raising concerns in certain situations. It recognises that in many cases of domestic violence, general practice is the first formal agency to which women present for help and that whilst they are unlikely to raise such facts directly, the contact with the GP can be *'used as a 'calling card': an apparently unimportant physical symptom to seek help indirectly'*. GP's must have confidence in their ability to intervene and to know the process of accessing expert help. If a practitioner is unaware of what services are available for a particular problem that individual is less likely to pro-actively seek to identify patients with these problems. [35]

6.39 GP practices in the Durham County and Darlington areas are encouraged to adhere to the RCGP's guidance. Health professionals working in a clinical role in primary care are required to be trained to level 3 standards according to the Royal College of Paediatrics and Child Health 2010.

6.40 There is no doubt that many friends, family and other were aware of what life was like for Adult A. Research detailed in *'If only we had known'* states: *'Much more attention needs to be given to communities, by which we mean neighbours, friends, family and colleagues of victims and perpetrators. Public campaigns should focus on increasing awareness of coercive control as it is this theme that family and friends return to in the aftermath of homicide – "if only we'd known". Advice from informal networks can be hugely influential in decisions to report and seek help. They also provide support and safety in the short and longer term. Information campaigns must therefore include messages which validate what members of informal networks currently do whilst expanding awareness and understanding.*

[35] RCGP Policy: Royal College of General Practitioners - Domestic Violence-The GPs role

"The community" needs to be recognised in the provision of a coordinated community response" [36]

6.41 It is imperative that professionals should take more recognition of what others are saying in relation to domestic abuse and what is happening within a family. Comments made by the GP's interviewed give cause for concern, although it is important to contextualise the progress of how domestic abuse is dealt with over the review period. For example GP2, although in response to a question concerning Adult A's excessive use of alcohol stated *"if a patient doesn't tell you about a problem again you would presume it has gone away".* It is essential to ensure that practitioners deal with facts as opposed to presumption and it is rare that problems such as alcoholism simply go away without some identification of how or indeed why. The simple matter is if a question isn't asked an answer is unlikely to be forthcoming and again is an example of how curious professionals need to be at all times. Further comments made by a GP interviewed of *"this sort of abuse is quite common in this area"* again exemplifies the need to ensure that practitioners look at the individual cases and not simply categorise in a generic response to 'issues'.

6.42 Analysis of the IMR shows the following positive changes that have now been introduced: The 'Front screen' of patient records has the facility to highlight issues of note to the practitioners and provides an immediate warning/guide. The publication of 'quick reference guides' for GPs dealing with patients presenting signs and symptoms of domestic abuse. Identification of a safeguarding lead for each GP practice is also seen as a positive change.

County Durham and Darlington Foundation Trust (CDDFT)

6.43 As previously indicated the IMR references a single occurrence of relevance that refers specifically to Adult A attending the Urgent Care Centre. Contextually, this was an important event taking into account the date of the actual incident, May 2011, which was just some seven months prior to the tragic events of January 2012.

6.44 The overview author observes that this was a key episode and the IMR makes clear that this visit by Adult A left a significant number of questions unanswered. Although the injuries to her were not apparently significant, Adult A displayed considerable anxiety and distress as well as smelling of alcohol. More importantly was the comment made by Adult A concerning her fears for her teenage son. This disclosure should have triggered a referral for the safeguarding by the practitioner of the child (toxic trio).

6.45 This CDDFT record does not appear to be cross-referenced to the GP Practice leaving another potential knowledge gap. The key issue in question within this IMR is the safeguarding of the identified child which received no apparent consideration and again is another example of the need for professionals to think 'outside the box'.

6.46 Analysis of the IMR shows the following positive changes that have been introduced: The recognition of a potential criminal assault and the offer of support and intervention to the patient by the assessing practitioner.

[36] London Metropolitan University, July 2007 'If only we'd known': an exploratory study of 7 intimate murders. Child & Woman Abuse Studies Unit LMU

North Tees and Hartlepool Foundation Trust (NTHFT)

6.47 It is noted that from the records available from the Trust's records that 3 records of attendance at Accident and Emergency could not be found, these were one by Adult A and two by Adult B.

6.48 The overview process recognises the IMR's observation that staff at an accident and emergency department are generally under greater pressure to provide urgent healthcare services within a particularly busy environment and that this is the rule as opposed to the exception. The comment from the professional guidance from the relevant time raised by the IMR author however that *'all we can reasonably expect is for A/E staff to do as standard is to provide immediate response to the presenting complaint and signposting to appropriate services',* is a conclusion whereby opportunities to intervene will be missed and could inevitably lead to more serious consequences. It is essential again that all health care professionals are able to think 'Safeguarding'.

6.49 At 5.1.2 the IMR observes that; 'There *is no indication that there was a failure by any individual within the Trust to safeguard the victim* '. The overview author does not fully agree with this premise as it is clearly the role of *all* health care professionals to be curious and inquisitive and therefore any lost chance to glean more information can only be seen as a missed opportunity and as thus is the responsibility of all individuals involved in that case. The Overview author does fully accept that actions were taken in line with practice and procedures that were in place at that time and positive changes have taken place since. However it should be borne in mind that the 'victim' in this case was not just Adult A but moreover Adults E and F (who were children at the time) as a picture of the home and what life was like again did not emerge. The overview report comments however that this is a feature of each of the IMR's and not just specific to the NTHFT.

6.50 It is also recognised that the practitioners provided Adult A with 'signposting advice' which took the form of leaflets and information to support agencies. Whilst this is regarded by co-ordinated action against domestic abuse (CAADA) and others as good practice, this process can never get to the heart of the matter and such action although necessary, should be accompanied by dialogue at the time of issue.

6.51 Analysis of the IMR shows the following positive changes: Providing appropriate literature and signposting may assist and support individuals who are otherwise reticent to give personal details to staff. It is important to ensure that the correct signposting is made and is personal to the service user and that the forms/leaflets are current and up to date. That all records completed are to be signed and endorsed with both a printed name and GMC personal identification number. The use of a self-assessment tool for patients attending the A&E in order to both raise awareness of excessive alcohol use and where signposting and referral for additional support and advice can be given, is seen as a positive step.

Newcastle College

6.52 The IMR from the Newcastle College is limited in content however the key information refers to a relevant interview of a member of staff for which a separate interview record has been appended.

6.53 The engagement by the member of staff, a learning mentor, was with Adult E and occurred in November 2011, just some 2 months prior to the incident in January 2012 and continued into December, just 4 weeks before the tragic events. The disclosure made by Adult E was of domestic violence that principally was directed against Adult A by Adult B. Adult E was asked if there were any children at risk and the response was that there were not. It was established that Adult E was not in any immediate danger. Whilst dialogue continued between the staff member and Adult E, it appears that no additional disclosures were made other than the fact that the police were involved.

6.54 None of this information appears to have been discussed in any detail and was not shared with other agencies. The overview, although identifying the proximity of the meetings to the incident of January 2012, accepts that this was a fact finding process that gave no immediate and urgent signs where action to refer would have been obvious.

6.55 Analysis of the IMR shows: In this case the provision of mentors to students is a positive step forward in a safeguarding arena as trust between the respective parties can be developed over a relatively short period of time. This acts in principle as 'community awareness'.

Section Three

7.0 Family and friends' involvement with DHR

7.1 The overview author is grateful to the DHR panel Chair Lesley Jeavons for her extensive interviews and contacts that she has made with family and friends of the respective adults There are some frank discussion points made by many and the overview author thanks the family and in particular Adult E for being so open and honest with their thoughts and feelings. The overview author also takes into account that the views are taken from both sides of the family and that there may be elements of assumption on the part of those interviewed as well as some personal opinions. Whilst it is important to understand the feelings of the families, it is crucial that the review is able to focus on the facts in order to offer an independent and impartial perspective. It is also accepted that many of the views are impassioned feelings which must not be disregarded out of context as none of the families have any specific diarised events or incidents recorded. Dates of incidents referred to must therefore be considered cautiously.

7.2 What is apparent from the accounts made either by letter or personal interview is that there is a clearly a different view within the wider family unit as to who was responsible for the alleged dysfunction within the family unit of Adults A and B. It is apparent that the family of Adults A, C & D place the blame firmly upon Adult B as both the aggressor and prime instigator of events. This is clearly transposed to the opposing perspective in respect of the family of Adult B with Adult A being the identified principle aggressor. They do however not in any way condone the actions of Adult B and would wish to pass on their condolences and sympathy to the family of Adult A. It is therefore difficult for the overview to make any unambiguous judgement concerning, in particular, Adults A & B in respect of who or what was the catalyst in each individual event. It is however a reasonable assessment that Adult A suffered the effects of frequent physical assaults at the hands of Adult B and it is alleged

that on occasions he too had injuries that were consistent with assault on him on the part of Adult A.

7.3 This suggests that although Adult A appears to be the victim in the instances of domestic abuse that were reported to the police and possibly those reported to the respective healthcare providers, that Adult B was also the victim of domestic abuse at the hands of Adult A, albeit to a lesser extent. It does appear that Adult B shared the information concerning some of this abuse with members of his family and they report that on occasions he was noted to have scratches and signs of minor assault. It is apparent that he either sought little or no medical advice for injuries or possibly concealed how injuries were sustained.

7.4 The overview author comments that it appears that Adult F declined to be interviewed in connection with the DHR. This is entirely understandable given his extreme traumatic experiences however it is perhaps of note that there were earlier opportunities in his life that would have allowed the child's voice to have been heard. It is of concern to note that although he has now attained 'adulthood' the longer term effects of the tragedy are likely to have a profound influence upon him. Whilst he may well have formed his own views and opinions from his personal experience, a lack of professional intervention should not be lost based upon the fact that he is now, in the eyes of the law, an adult. This needs to be given due regard with any examination of him as a witness at inquest.

7.5 The overview author also acknowledges the information from members of the family concerning a visit made to Thailand by Adult B, which was made without his family (and it is suggested without prior knowledge of Adult A) It is further suggested by Adult A's family that Adult B's alleged infidelity was a frequent catalyst for the disputes between them. A member of the family of Adult A gave information of incidents of sexual violence by Adult B on Adult A that whilst being fully acknowledged cannot be corroborated by the overview author.

7.6 The families of Adults A &B during their meetings or submissions to Mrs Jeavons voiced a number of recommendations themselves which are worth the multi-agency partners listening to and taking notice of.

The main actions identified by both families are summarised by the review author as:

- *The law on awarding gun licences needs to change as it is not right for the decision to be left up to one police officer and we would like to see a panel introduced of at least 3 people, including a doctor and police.*
- *This panel should be the police, a firearms expert and a doctor's report to say if you are stable.*
- *Cautions for violence should count as criminal convictions when awarding a gun licence.*
- *Posters highlighting domestic abuse and how to report it should be in public places, TV, radio and the internet. It is just not publicised enough, I have never seen it.*
- *An awareness campaign in secondary schools should take place into publicising domestic abuse.*
- *GP's should have a button that says if there is domestic violence or mental abuse and (he) is a gun owner, the warning signs would be there, and then people like that*

wouldn't be granted a gun licence (sic). (It should be noted here however that current (2011) BMA guidance for GP's on firearms licencing is not compatible to some of the recommendations that both the family and the DHR panel have made. For example the enduring marker is not recommended by the BMA. Recommendations at 6 a, b & c will try and resolve these issues, firstly through Durham Constabulary and the Local medical committee and then through ACPO and the BMA).

7.7 Perhaps one of the most humbling of comments in this case from the son of Adult C when asked what message would you give to other families suffering domestic violence.

"Do something about it, doesn't matter how scared you are, find the strength to report it, get out before you end up dead".

7.8 The overview author acknowledges that this overview report has been shared with the respective families and that some of the language and observations herein may have been difficult to read. However the overview author and the panel chair wanted to ensure that the families are made aware of the independent perspective and that commentary is based purely upon analysis of the content of the IMRs and briefings with the panel, authors and information from the respective family members and friends.

Section Four

8.0 Conclusions

8.1 There is no doubt that a number of improvements have taken place within the timescales of this review period. This is in relation to the activity of all multi-agency partners within County Durham in respect of domestic abuse and is acknowledged as a development within this overview report.

8.2 Some examples of service development across Public Health within County Durham and Darlington are outlined below:

- For the last year dedicated funding has resulted in two workers being employed by the Derwentside Domestic Abuse Service to work in schools to deliver a RESPECT programme. This covers a lot of the issues of domestic abuse including impact from domestic abuse, signposting to services, and the issue of teenage partner violence as well as the value of developing respectful relationships.
- The Domestic Abuse Action Plan includes the need to continually train health professionals.
- An annual domestic abuse campaign takes place in line with International Women's Day.
- A new outreach service will have a key role in promoting the service in a range of venues including GP practices, dentists, A&E and on the back of toilet doors in a range of community venues.
- A dedicated Community Alcohol Service was established in 2009 across County Durham. All staff are trained in dealing with domestic abuse and there is a referral pathway between the alcohol service and domestic abuse service. The risk assessment paperwork identifies victims of domestic abuse as higher risk/vulnerable

client group and the criteria to access the service is lower than for the general population given this risk. In this case alcohol was a critical factor so this is seen as very positive.

- Work is underway to explore the feasibility of establishing an alcohol clinic in A&E over a weekend period and recent guidance also suggests that a similar approach should be taken with domestic abuse.
- Police officers have been trained to undertake alcohol screening and referral to the alcohol service if someone is arrested/in custody. This is important when working with perpetrators.

8.3 There is however further national learning that can be applied to this DHR. In *' Call to End Violence Against Women and Girls'* (VAWG) the difficulty in being able to fully identify the prevalence of violence against women and girls is expressed that it is often a hidden crime. Research however reveals an appalling picture:

- At least 1 in 4 women in the UK will experience domestic abuse in their lifetime (British Crime Survey 2009/10)[37]
- Almost 1 in 5 women will experience sexual assault in their lifetime (British Crime Survey 2009/10)
- Almost 1 in 20 women was stalked last year and 1 in 5 women will experience stalking in their lifetime (British Crime Survey 2009/10)

8.4 British Crime statistics for 2009/10 show that:

- Domestic violence accounted for 14% of all reported violent incidents
- 7% of women and 4% of men suffered domestic abuse during the year
- Women were the victims in 77% of incidents
- Domestic violence had the highest rate of repeat victimisation of any serious crime. 47% of victims experience more than one incident; 30% more than three

8.5 There is also a significant impact on children:

- At least 750,000 children a year witness domestic violence (Department of Health, 2002).
- Children who live with domestic violence are at increased risk of behavioural problems and emotional trauma, and mental health difficulties in adult life (Stanley 2011)
- 52% of child protection cases involve domestic violence (Farmer & Owen, 1995)
- 40% to 70% of men who assault their wives or partners are also directly physically or sexually violent to their children or abuse or threaten the children to increase their control over their mother (Hester and Pearson, 1998, Humphreys, C. and Mullender A, 2000)

8.6 The Government's strategic vision and the VAWG action plan places prevention and awareness- raising, early identification and early intervention at the centre and contains measures for central government to:

[37] It is also acknowledged that 1 in 17 men will be killed as a result of domestic abuse and that two women a week will die as a direct result of domestic abuse.

- Prevent violence from happening by challenging the attitudes and behaviours which foster it and intervening early where possible to prevent it.
- Provide adequate levels of support where violence does occur.
- Work in partnership to obtain the best outcome for victims and their families.
- Take action to reduce the risk to women and girls who are victims of these crimes and ensure that perpetrators are brought to justice.

8.7 It is clear that a number of the issues raised by the VAWG action plan mirror the life of Adult A and her children. It cannot be said with definite certainty that if this action plan had been in place during the years that are covered by this review whether life for Adult A, her children and their ultimate safety would have been improved, but there is a strong probability that it could have made the opportunity for it to be better.

8.8 Issues of prevention and awareness-raising, early identification and early intervention are of significance in the case of Adult A. The learning from this DHR and ensuring all aspects of VAWG action plan is implemented across all partners in Durham County will pay significant dividends to the prevention, early identification and interventions to similar situations and lives to those of the experiences of Adult A and the family.

8.9 The overview author found it of significance in relation to the well-known impact of DA on the emotional and psychological welfare of children, that Durham Social Services had only limited information passed to them. Of even more significance was the fact that the Head of Education when asked by the panel chair to check the records for the primary and secondary schools that Adult E &F attended that they had no information with which to assist this DHR. This highlights the need for an informed communication process over a range of disciplines. Although a communication framework under safeguarding protocols exists this should be re-visited in the light of procedural and organisational changes to ensure that this is fit for purpose across all agencies that have the ability and opportunity to make early identification of the potential for abuse and welfare concerns.

8.10 A key question is why the nature of Adult A's relationship with Adult B prevented her from seeking external support given the apparent voracity of the attacks as described by her siblings. It is of note that a number of those engaged with acknowledge that there is little overt publicity in respect of domestic abuse, although the overview would tend to support that there is perhaps limited publicity that could be more pro-active, publicity does exist as do the facilities for referral.

8.11 It is difficult to say with conviction that the death of Adult A could have been prevented. The permanent removal of Adult B's firearm's and shotgun licences would certainly have prevented one form of weapon being used by him. However the overview acknowledges the fact that Adult B shot and killed Adult's A, C & D and injured Adult E and that this can only be attributable to the fact that he had the lawful possession of weapons at that time.

8.12 Whilst it is therefore challenging to state within any certainty that any of the subject adults' deaths was either predictable or preventable there were clearly missed opportunities across a range of service providers, where incisive investigation, intervention and diversion would have been able to establish and examine in more detail the violence, and alcohol abuse, within the home environment. This would have raised overall concerns about both

family and possibly the wider matter of public safety. Even if any of the missed opportunities had in fact been taken and completed in line with what is regarded as best practice, it cannot be said with any conviction that they would have made a difference to the eventual tragic consequences. The family of Adult A may feel that had Adult B not had the weapons that this tragedy would not have occurred. This is a strong point of view and although it cannot be conclusive is nevertheless understood by the overview author.

8.13 There is also conflicting information received from family members and friends as to whether this death was predictable, which makes it difficult to again with any certainty state that Adult A's death was as they argue, predictable. The overview author from the information available is of the opinion that Adult A's death was not predictable any more than research suggests in all cases of domestic abuse. However with the right processes and support from not just agencies but those close to her who were aware of the abuse, her death may have been preventable, if she had been willing to engage in allowing this to happen. HM Coroner for Darlington South Durham/North Durham Districts at the conclusion of the inquest stated:

'In my opinion these deaths were avoidable. The systemic shortcomings highlighted by me today lead me to conclude, that on a balance of probabilities, the four deceased would not have died when they did in the manner they did had there been robust, clear and accountable procedures in place.'

8.14 Gaps made in reporting and communication with and between agencies (as well as intra-agency) are not uncommon as in this case however gaps will continue to occur, but practice should reflect the efforts made to minimise such occurrences. No single individual or agency can be held to account, a view further endorsed by the Coroner.

8.15 There were occasions when good practice was undertaken by professionals, for example when Adult B was arrested and cautioned, but critically these were not able to challenge or influence the need for a more co-ordinated response by professionals acting in consultation under existing protocols that was ultimately required in order to provide more effective interventions to the domestic abuse, violence and safeguarding issues within the family environment.

8.16 If instances or concerns about the existence of domestic abuse and violence are not consistently seen by professionals as also being safeguarding issues, then this will have inevitable consequences in that children will fail to be safeguarded against both physical and emotional harm.

8.17 To make assumptions or presumptions about the actions or decisions of other professionals without checking these out and seeking confirmation or evidence to qualify them in whole or even in part is a dangerous precedent, as was shown when Adult A attended the GP surgery and they believed that the police were already involved. To take a passive stance in deciding that there is no requirement to confirm specific actions have been undertaken or acknowledged to protect children or a vulnerable person leaves a potential risk of harm.

8.18 Although individuals may not display obvious signs and symptoms of abuse the volume of visits to healthcare environments with a range of issues over a period of time may be a cry for help, where the service user is not able to make informed decisions about their

or their family's welfare. It is they who require ultimate support, guidance and intervention and are unlikely to simply seek it of their own volition. In this respect it is crucial that all practitioners are adequately trained and if not that the GP practice ensures the opportunity to defer to expertise within other professionals. Notwithstanding that this did on occasions take place, there was no continuity and certainly limited professional curiosity on a number of occasions.

8.19 The overview author also acknowledges the concerns that practitioners have regarding disclosure of records (particularly from a medical perspective) due to confidentiality issues. The overview clearly does not endorse any ad hoc disclosure, however a common sense approach needs to be taken and if necessary agencies should be clear about limitations. In this case had one incident of domestic abuse been revealed to the police that they were not aware of, this could have opened opportunities to provide an enhanced service to the respective victim through existing protocols. Equally are there opportunities to address an intelligence perspective without overtly overruling confidentiality. This is an area that needs to be robustly explored by the respective agencies legal advisors where further clarity is required particularly concerning access to medical records and any link to firearms applications.

8.20 Whilst both public and professionals are often told that the Data Protection Act does not inhibit agencies from sharing information, it also does not positively encourage or require it; nor, critically, does it explicitly offer protection to those charged with making the judgments about sharing sensitive personnel data in cases of suspected risk. Sharing information from client patient records for DHRs appears to create more difficulty than it does for serious case reviews in the case of safeguarding children, due to the need on occasions to get consent. This needs to be factored into the timescales in order to complete IMRs.

8.21 The overview author has to conclude that each incident appears to have been dealt with as a single occurrence as opposed to the wider picture being considered where the historical facts (irrespective of policy and procedure) should have amplified concerns.

8.22 In conclusion what is apparent to the overview author however that no individual or single agency can be held to account for the tragic deaths of the victims in this case, although it is apparent that all agencies must look at their own systems and processes and inter agency notification practices. In so far as the matters pertinent to the firearms are concerned, there are clearly a number of matters for the Durham Constabulary to address arising from the investigation by the IPCC. What is apparent from the constabulary's internal firearms licencing review and the IPCC investigation to the overview author is that there were not at the time enough robust procedures taken to ensure the applicants (Adult B) suitability to hold weapons.

9. Overview Recommendations

9.0 This overview report has examined what happened in this case, and has also used this case as an example of how the multi-agency partners within Durham County have dealt with issues of not only domestic abuse but also the safeguarding of children. The overview process has also sought to identify why things happened. The following recommendations are aimed at ensuring improvements take place to prevent further tragic deaths, and to

ensure better outcomes for victims of DA. In relation to safeguarding children many of the recommendations already contained within the action plan incorporate potential benefits to children and young people. However, this report has been shared with the Durham Local Safeguarding Children's Board for them to progress any additional actions in keeping with their statutory duties.

Recommendation 1:

The Safe Durham Partnership Board (SDPB) through the Domestic Abuse Focus Executive Group (DAFEG) develops a protocol to deal with DHR's including timescales and processes that all of the partners sign up to and adhere to.

9.1 The panel chair has expressed concern on the amount of time that it took for some agencies to complete their IMRs. The timely completing of IMRs will enable an early opportunity to learn lessons. Within the completion of some of the IMRs it is seen that some practitioners were not interviewed. The overview author considers this to be an oversight as there are practitioners mentioned whom it is considered could have offered more value to the respective IMRs. This perspective is recognised as being good practice and can be addressed across a range of disciplines such as personal interviews, written responses and questionnaires, which can frequently add value to the overall report process. The agencies are also reminded that whilst there are no apparent issues of particular sensitivity in this case it should be noted that ethnicity, culture, language and issues of diversity should at all times be recognised in practise and in reporting, both within IMRs and professional practice.

Recommendation 2:

The Safe Durham Partnership, through the Domestic Abuse Forum Executive Group has already considered the VAWG action plan; they should review the activity that they are taking to implement this action plan across County Durham.

9.2 The 'Call to End Violence Against Women and Girls' action plan is now embedded well in areas throughout the Country. Within this action plan the action points have been designed that if carried out would have helped to keep Adult A safer and also improved preventative activity to safeguard victims of domestic abuse.

Recommendation 3:

The Safe Durham Partnership Board should review its existing information sharing protocol and ensure it is fit for purpose in relation to domestic abuse and firearms licencing. Consideration should be given to the inclusion of specific addendums that include what information is to be shared by whom and under what circumstances and so that those expectations are clear to all staff.

9.3 The prevalence of the lack of inter and intra agency communication highlights the need for an informed communication process over a range of agencies. Although a communication framework under protocols exists this must be re-visited for domestic abuse and firearms licencing in the light of procedural and organisational changes to ensure that this is fit for purpose across all agencies. This will bring about improved information sharing and assessment of risk.

Recommendation 4:

a) The Central Referral Unit defines for all partners what its role and function is.

b) The CRU urgently considers incorporating primary and secondary health services into the CRU.

c) Further consideration is given to the Central Referral Unit becoming a fully functioning Multi-Agency Safeguarding Hub (MASH)

9.4 Durham Constabulary has a Central Referral Unit that also has multi-agency partners within and 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 and a result of this safeguarding both children and adults, is nationally regarded as good practice and has been highlighted in a number of National and Governmental reviews as best practice.

The Durham Constabulary CRU is progressing well, but still lacks a permanent Health presence within. In the case of Adult A the information that would have been shared through the MASH and 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 health professionals linking into the MASH.

The panel take seriously the need for robust processes which encourage information exchange and the importance of effective information sharing is reflected in recommendations 3, 4, 5 and 6.

Recommendation 5:

a) Although no illegally held weapon was used in this case; when an incident occurs which warrants the seizure of weapons from a licenced shotgun or firearms holder, all certificates are seized.

b) Before the decision to return any weapons is made, full recorded checks are undertaken both internally and externally, to determine the fitness of the licence holder to return the weapons and certificates to.

9.5 On the 10th September 2008 as a result of a report that Adult B was going to '*blow his head off',* the police attended and removed his firearms, and arrested him. He was subsequently released without charge. There is no record of the shotgun certificate also being seized, which would have been good practice as he could simply have acquired other weapons by his possession of a valid certificate. On the 24th November 2008 the firearms were returned with a final stern warning about future conduct. It is felt that more involved process of checks in relation to the background to the domestic incidents must be conducted whereby the police are able to suspend or withdraw the respective certificates and licences based upon the balance of probability. Such decisions should ultimately be made by the Chief Officer. The IPCC investigation and the internal police review of firearms licencing supports and adequately addresses this recommendation, through the writing of a policy that is issued to all staff.

Recommendation 6:

a) The police firearms licensing department explore the feasibility of carrying out checks both internally and externally, on the applicants relevant history with other agencies in particular primary health care i.e. GP's, to help them makes decisions in relation to the granting of either a shotgun or firearm license or a review of same. This will enable information to be shared relevant to domestic abuse, substance misuse, physical harm and mental health issues. During the course of their enquiries both at application stages and review or at any other time where intelligence indicates there may be issues of concern about a member of the same household checks will be undertaken in respect of that individual with their GP.

b) Once a firearm or shotgun certificate has been awarded, the police firearms licencing department should notify the individual's GP so that they are proactive in their information sharing if they have concerns about the certificate holder and their appropriateness to continue to hold these certificates.

c) During the course of those discussions the police representative should also seek permission for a 'flag' to be placed upon the individuals medical record which identifies that if granted a licence it is clearly visible to those accessing the record.

9.6 It is a fact that Adult B made an application for the grant of a shotgun certificate to Durham Constabulary on October 10th 2006. This was granted on the 7th February 2007.

It is a further fact that Adult B made an application for the grant of a firearms licence to Durham Constabulary on the 7th February 2008. This application was granted in May 2008 although the actual date cannot be qualified by the overview.

There would not appear to be any record of Durham police's firearms licensing department, contacting, during the decision making process to grant these licences, with their internal safeguarding department, or any partners in particular primary health through the applicants GP. This would have highlighted his DA incidents and also identified the significance of the level of alcohol abuse. A family member of Adult A has put forward similar thoughts to this recommendation as a petition.

The guidance from the BMA in relation to firearms, titled' Firearms – Guidance from the BMA ethics department' is not supportive of this recommendation due to advice given to them by the information commissioner. The Durham Constabulary internal review of firearms licencing has addressed this as one of their recommendations and has already sought to resolve this through the local medical committee (LMC) and then following a pilot evaluate the results to see if this pilot can be continued and extended. The Safe Durham Partnership need to support the police (ACPO) & the LMC to challenge the current (2011) British Medical Association (BMA) guidance, this will also include communication from DHR panel chair Mrs Jeavons to the information commissioner, this will enable the SDPB to be pro-active to gain appropriate changes, the SDPB also need to ensure that recommendations made in both the IPCC report and the internal firearms licencing review are implemented.

Recommendation 7:

The training of professionals is to include understanding the importance of not assuming that other professionals are aware, and taking appropriate action in light of each individual set of circumstances

9.7 In the case of healthcare professionals there was a significant reliance on the presumption that another agency or agencies were dealing with the domestic abuse that Adult A was suffering. An example from the GP's Practice appears as stated on the record dated 25th July 2002 '*police and solicitor involved'*. This actually wasn't the case as this was in fact a further incident of domestic abuse that had occurred since the reported incident of the 14th July 2002, where Adult A had not suffered any apparent injury as that reported on the latter occasion. It is important within domestic abuse training that GP's and supporting practice professionals understand the importance of not making assumptions that other professionals are aware and will or have been taking appropriate action.

Recommendation 8:

The Domestic Abuse Forum Executive group consider that each agency, where not already identified, appoints and trains at least one member of staff to be the operational lead for domestic abuse.

9.8 It is critical that each respective practice and agency has a lead in matters of domestic abuse to ensure that any question of concern can be adequately addressed within each agency. Current Department of Health guidelines state that the successful implementation of policy and guidelines for domestic abuse relies on a comprehensive education and training programme. All staff who have contact with patients should be trained in domestic abuse issues – this includes administrative and reception staff (DoH, 2005) [38].

Recommendation 9:

An approved DAFEG 'package' of leaflets and information is made available to all health agencies that encompasses both domestic abuse support and guidance and also signposts other organisations and charities

9.9 It is noted that the IMR'S refer to literature and signposting being made during the period of engagement with Adult A. What is not apparent is the type, level and current content. The overview is concerned that the literature should be current and topical but also be broader in its diversity, given the range of people that it can be offered to. A suggestion is that an approved 'package' of leaflets and information is made available to all agencies that encompasses both domestic abuse support and guidance but also signposts other organisations and charities, for example Addiction, Alcoholics anonymous and in particular other local or regional initiatives that are up to date. These 'packages' should be re-visited by agencies on an annual basis to ensure that they are current.

[38] Responding to domestic abuse: a handbook for health professionals. Department of Health. December 2005

Recommendation 10:

The Safe Durham partnership explore with other police forces and partnerships nationally including Co-ordinated Action Against Domestic Abuse (CAADA), for an innovative way to capture third party reporting in relation to DA.

9.10 It is accepted by the overview in commentary that much of the history was concealed within the household and although known to friends and family, it was not revealed to any significant extent outside of this close circle and was certainly not reported to the police by third parties. Had such information been known to the police and other partners it is a reasonable conclusion to reach that a more robust picture would have emerged in particular concerning the intemperate habits of Adult B.

Recommendation 11:

The Safe Durham Partnership Board should consider the opportunity to establish priority stakeholder workshops to examine this DHR as a case history from reporting to conclusion in a useful table-top exercise.

9.11 It is essential to ensure that there is a consistency of service provision across each of the specialist domestic abuse services and continue to work towards achieving nationally accepted standards of best practice. Continued training and information to front line practitioners to improve confidence with identifying victims and making appropriate referrals is essential in achieving this.

9.12 The Safe Durham Partnership Board should now agree the proposed recommendations and develop an action plan to drive the recommendations forward and to monitor and review progress on a regular basis with a nominated date for conclusion.

Recommendation 12:

The Housing Solutions Service should explore the development of a protocol which supports the effective information exchange with the Police Domestic Abuse Service.

9.13 Whenever a request if made for re-housing due to allegations of child or domestic abuse, Housing Solutions should always refer this information to either the police or a MASH if and when one is established in County Durham.

9.14 The evidence to support this recommendation is that in this case Adult A made an application to Durham County Council Housing Solutions to be re-housed due to a marital breakdown and that the family home was ready to be sold. The application indicates that she stated “husband drinks a lot and is starting to be violent towards daughter”. However, the application remained open although there was no further contact from Adult A in this respect with Housing Solutions who, at this point were part of the Local Authority. The application was never closed and remained open with the Local Authority until the death of the applicant was notified to them.

10. IMR Specific recommendations

The following recommendations have been made by the authors of the respective IMR's and are subject to SMART action plans which are to be reviewed by the Safe Durham Partnership Board and actioned accordingly.

10.1 North Tees and Hartlepool Foundation Trust

- The NTHFT should ensure that relevant learning identified in this Domestic Homicide Review is shared with staff working in relevant areas within the Trust
- The NTHFT should ensure staff working in the A/E departments and Minor Injury Units within the Trust are aware of the importance gathering all relevant information from victims of domestic abuse and that they provide victims with appropriate information on how to access support services
- The NTHFT to seek confirmation/assurance from their training provider that considering the potential risks to children living in families where domestic abuse has been identified should continue to be an integral part of safeguarding children training

10.2 Durham Constabulary

- To undertake a full review of all firearms' certificate holders to ascertain if any are perpetrators of domestic abuse or have been previously identified as such. This action is currently underway.
- Durham Constabulary to finalise a firearms review once the independent report is received from the IPCC. (see below)
- The Safe Durham Partnership to consider innovative ways of third part reporting. The DA executive Group is to oversee a working group.
- Durham Constabulary needs to complete the awareness campaign for front line officers of what services are available to victims of domestic abuse.

The finalised Durham Constabulary 'Firearms Licencing review makes the following recommendations.

- Staffing-Licensing function to be part of constabulary's operational core business, with long term investment of operationally capable staff.
- CRU- Ensure risk based approach through effective use of police/partner agency information.
- On-going risk assessment- Ability to identify policing activity involving firearms certificate holders.
- Domestic abuse-framework based on risk using constabulary's experts and a robust response.
- Information technology- Force's systems support firearms licensing.
- Police system checks- systems to recover all information about a certificate holder.
- Medical information- interpretation of medical conditions / medications and risk, consent Vs honest disclosure.
- Risk assessment of new firearms licence applications.
- Impact of Service level agreements.
- Public Confidence.
- Manage on going risks- police tactics going forward.
- Record keeping- consistent/ accurate record keeping.
- Training and development of licensing staff.

10.3 NHS County Durham and Darlington for Primary Care

- The Safeguarding lead(s) within each clinical commissioning group for each GP practice needs to be made aware of existing training and updated when new opportunities arise so that they are able to cascade this information to the practice team.
- A 'Quick Reference Guide' to be developed by the author of the IMR and disseminated to all local surgeries via their safeguarding lead(s) which will include the recommendation that practices identify at least one member of staff to take a lead on domestic abuse.
- A mechanism needs to be established by the author of the IMR report to ensure that key information such as this is brought to the attention of front line professionals via the Safeguarding lead(s) at the practice.
- The PCT and clinical commissioning groups needs to ensure that the future commissioner(s) of counselling services for Primary Care consider this issue and includes the requirement that counsellors contracted to provide this service attend formal Safeguarding Children Training in line with the intercollegiate Guidance (RCPCH 2010)

10.4 County Durham and Darlington Foundation Trust

- To ensure appropriate literature and contact numbers are available for those affected by domestic abuse.
- To ensure Safeguarding Children's training captures the importance of considering risks to children where domestic abuse is known.
- To identify a domestic abuse lead/champion within the Urgent Care Centre(s)
- Practitioners are to be trained to at least level 3 Safeguarding Children
- To ensure that lessons learnt are shared across the organisation.

11. The Independent Police Complaints Commission

11.1 The overview author is grateful for the provision by the IPCC of a copy of the final report into their investigation concerning the granting, management and review of Adult B's shotgun certificate and firearms licence by the Durham Constabulary. The overview author has also had copy of the learning the lessons report that the IPCC have also compiled and all relevant findings have been taken cognisance of by the Panel chair and overview author for the recommendations in this report.

11.2 Both are a comprehensive report compiled by a Lead Investigator for the Commission which examines in detail the background concerning Adult B's application and subsequent grant of both a shotgun certificate and firearms licence. The overview report does not intend to rehearse the reports in detail and comments that a review by the force into current practise within the Durham Constabulary's Firearms licencing department is underway. The overview author endorses this perspective.

11.3 What is clear from the report is that significant concern has been raised not only to Adult B's acquisition of weapons, but his retention following later incidents where opportunities existed for revocation of his respective authorities. For the family, this will continue to be a source of much of their continued efforts to have a voice.

11.4 Importantly the IPCC has acknowledged that no individual can or should be held to account for decision making. It further indicates that there should be no criminal or misconduct charges arising from their investigation.

11.5 The report also identifies that officers are frequently concerned that a refusal of the grant of respective firearms authority will lead to legal challenges. The overview process agrees with the findings of the report that suggests that the police must be robust and challenging throughout in all aspects of an applicant's suitability to acquire and hold what are lethal weapons no matter what the premise of the applicants needs to hold weapons are. Whilst this is a matter for the Durham Constabulary, it is also a matter that a number of other police forces will need to consider in the wider scheme.

11.6 The findings from the learning the lessons report are detailed below and Durham Constabulary have adequately addressed all of them or are in the process of doing so.

- Liaison with the Domestic Violence/ Safeguarding Unit
- Procedure following the seizure of weapons and the systematic identification of licence holders.
- Recording decisions around applications for shotgun certificates and firearms licences
- Local policy outlining roles and remit within the firearms licencing unit
- Use of Warning letters.

12. Coroner Rule 43 Report

12.1 The Coroner has issued a Rule 43 report in this case. The Coroner has legal power to write a report about the case following an inquest. This is known as a 'report under rule 43' or a 'rule 43 letter' because the power comes from Rule 43 of the Coroners Rules 1988.

This Rule provides that where the evidence at an Inquest gives rise to concern that circumstances creating a risk of other deaths will occur or will continue to exist in the future, and in the Coroner's opinion, action should be taken to prevent the occurrence or continuation of such circumstances, or to eliminate or reduce the risk of death created by such circumstances, the Coroner may report the circumstances to a person who may have the power to take such action

12.2 In relation to the deaths in this case of Adults A-D, it is important that the DHR and the SDP learn and act on as many lessons that they can. The Coroner for Darlington & South Durham/ North Durham Districts makes the following suggestions for action within his rule 43 report for this case[39], they relate to training in regards to those staff involved in firearms licensing, including robust decision making and multi-agency approach in relation to information sharing, and liaison to managing the risk that the holding of firearms present.

12.3 *The inquest has revealed disturbing issues on the question of* ***training****. Notwithstanding the significant importance of the shotgun/firearms licensing process there was no formal training courses available in 2006/2008 and even limited formal training available now. Training was by virtue of learning on the job and by making enquiries one's self and familiarising one's self with the Home Office and ACPO guidance.*

[39] The use of bold for words in this section, are not in the original rule 43 report, but are highlighted by the overview author as the point that needs action.

12.4 *Guidance states that there should be a clear **decision making process** which should be robust and capable of being reviewed. Durham Constabulary in 2006/2008 did not have such a clear system. Had there been a robust and clear decision making process then the file itself would have given a clear indication of what information was known by whom and when and what the basis of the decision making process was. The absence of these needs to be addressed. There was no policy in place to quality assure the decision making process with regard to matters generally or at all.*

12.5 *With the paramount objective of public safety in mind, there appears to be a good evidence to support a **multi-agency approach** to the questions of firearms licensing where there is recognition of the fact that other agencies may have pertinent information which may not be accessible to or known to the investigating police officer. For example, enquiries might be made of a GP or other agency that might have knowledge of the applicant's partner/ spouse/ wider family which could be of direct relevance as to the sustainability and character of the applicant. Again, I accept that the concept of a multi-agency approach may not be simple or straightforward but if such changes to guidance, practice and procedure were implemented and just one life be saved as a result or serious harm prevented then such a review would be worthwhile.*

*The concept of **multi-agency liaison** is now much more widespread in other areas of policing, such as vulnerable adult protection, child protection, serious crime investigation than it was in 2002 (the date of ACPO and Home Office guidance) and these matters referred to in the review are worthy of immediate and detailed consideration. Durham Constabulary now has closer involvement with GP's and is trying to forge better links with other health care service professionals. Accordingly, this Rule 43 letter has also been sent to the B.M.A, G.M.C and the Department of Health. Primarily though I consider this a matter that needs to be considered by the Home Office most urgently*.

12.6 *I have heard detailed evidence of the review that has been undertaken by Durham Constabulary in the year or so that has passed since these tragic deaths. The Constabulary are to be congratulated for having undertaken such a thorough review and to have amended processes in advance of the findings of the IPCC being made known and also this inquest being heard.*

13. Additional family comments

13.1 In closure, the family of Adult A have expressed views that the Chair of the Domestic Homicide Review and the overview author consider worthy of inclusion within this overview report.

13.2 This expression of view is a direct quote from the family of Adult C and perhaps expresses the feelings that have been echoed by them in an e petition[40] of which follows is an extract.

[40] http://epetitions.direct.gov.uk/petitions/41060

- ***Licensed gun owners have used their weapons to kill or seriously injure innocent victims. Since gun ownership is a privilege in this country, and not a right, we urge the government to tighten licensing procedures to ensure that:-***

1. ***People with criminal convictions, or a history of domestic violence, or mental instability, or alcohol or other substance abuse, are barred from owning firearms.***
2. ***An enduring marker appears on gun owners' medical records and relevant information regarding gun owners is shared between police, licensing authorities and health professionals.***
3. ***A single, rigorous licensing system is introduced which includes shotguns and Sec 1 firearms and which requires a good reason for the possession of each and every weapon.***

13.3 The panel chair and the overview author would add that the family have shown considerable resilience and dignity and thanks them for their help in the compiling of the DHR overview report.

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