Safe Durham Partnership Board

A Domestic Homicide Overview Report

An Independent Report concerning the Homicide of Adult A

Chair of the Panel: Gill Findley, Director of Nursing for Durham Dales, Easington and Sedgefield Clinical Commissioning Group

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Section 1: Introduction

1.1 The commissioning of the review

1.1.1 This overview report has been commissioned by the Safe Durham Partnership Board concerning the homicide of Adult A 2012. It was requested at the Safe Durham Partnership Board meeting in February 2013. This report has been compiled by Mr Russell Wate QPM MSc, supplied by RJW Associates, who is independent of the Safe Durham Partnership and all agencies associated with this overview report. He is a former (retired) senior police detective and his expertise in child protection has received national recognition and he travels internationally presenting courses to healthcare professionals and law enforcement agencies. He is the current Independent Chair of the Peterborough Safeguarding Children's Board (LSCB) and has previously been the Independent Chair of the Hammersmith and Fulham LSCB. RJW Associates have extensive experience in the preparation of IMRs, SCRs and overview reports including domestic homicide reviews.

1.1.2 It is important to understand what happened in this case at the time and to examine the professionals' perspectives within context. This review will be used to broaden professionals' awareness and to ensure that best practice is embedded and that any learning is maximised both locally and nationally.

1.1.3 The death of any person in circumstances such as this is a tragedy and in this case close members of the family are still coming to terms with the longer term effects of these tragic deaths. The family of the victim have been consulted during the review process and their views are reported within this document. Contact with the family was made by the Independent Chair of the domestic homicide review (DHR) sub group panel, Gill Findley with the support of the Police Family Liaison Officer (FLO). The overview author is grateful for this input and the information obtained as a consequence of this contact.

1.1.4 The following agencies have contributed to the Domestic Homicide Review by the provision of reports and chronology. A decision was taken not to request IMRs from the agencies involved. The rationale for this decision is given at section 2.4.

- Durham Constabulary
- Durham County Council, Children's Safeguarding Team
- NHS – GP Practice
- Durham Tees Valley Probation Trust
- Tees Esk and Wear Valleys NHS Foundation Trust (TEWV) (Mental Health Services Provider)

1.2 The review panel

1.2.1 The Chair of the review panel was Gill Findley, Director of Nursing for Durham Dales, Easington and Sedgefield Clinical Commissioning Group, who is independent of the case and the organisations and agencies contributing to the review. She had no previous knowledge or association with any of the subjects of this review prior to the commissioning of this review and her appointment as the DHR Chair. Gill has over 25 years' experience as a Registered General and Registered Sick Children's Nurse and is experienced in dealing with managerial and clinical matters relating to safeguarding and domestic violence and abuse

1.2.2 The panel is made up of membership from the following organisations.

- Durham Constabulary
- County Durham Youth Offending Service (CDYOS) (first meeting only)
- Durham County Council, Children and Adults Services
- Durham Dales Easington and Sedgefield CCG (Chair)
- North Durham CCG representing GP Practices
- Durham Tees Valley Probation Trust
- Tees Esk and Wear Valleys NHS Foundation Trust (TEWV) (mental health services provider)
- County Durham and Darlington Foundation Trust (acute and community services provider)
- Durham County Council Community Safety.

1.2.3 The panel met 4 times during the review process between June and December 2013

1.3 Reason for conducting the review

1.3.1 A Community Safety Partnership (CSP) has a statutory duty to enquire about the death of persons where domestic abuse forms the background to the homicide and to determine whether or not a review is required. In accordance with the provisions of the Domestic Violence, Crime and Victims Act 2004, Section 9, Domestic Homicide Reviews (DHRs) came into force on 13th April 2011. The act states that a DHR 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

1.3.2 For the purpose of this DHR and overview the definition of domestic violence is in accordance with the cross-government definition:[1]
Any incident of threatening behaviour, violence or abuse [psychological, physical, sexual, financial or emotional] between adults who are or have been intimate partners or family members, regardless of gender or sexuality.[2]

1.4 Terms of reference

1.4.1 The Safe Durham Partnership Board agreed that in this case the death met the criteria of the act and statutory guidance and commissioned a Domestic Homicide Review (DHR)

1.4.2 The following terms of reference (TOR) have been determined by the Chair of the review panel:

To establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations worked individually and together to safeguard victims.

1.4.3 The following additional terms of reference were endorsed by the panel both for the individual IMRs and this overview report

1.5 Purpose of the review process.

1.5.1 The purpose of the review is to:

- Establish the facts that led to the incident in 2012 and whether there are any lessons to be learned from the case about the way in which local professionals and agencies worked together to safeguard the family.
- Identify what those lessons are, how they will be acted upon and what is expected to change as a result.
- Establish whether the agencies or inter agency responses were appropriate leading up to and at the time of the incident in 2012.
- Establish whether agencies have appropriate policies and procedures to respond to domestic abuse and to recommend any changes as a result of the review process. Domestic Homicide Reviews are not inquiries into how the victim died or who is culpable. That is a matter for coroners and criminal courts.

[1] Home Office Statutory Guidance - March 30th 2011
[2] The amended definition for domestic violence and abuse was published in March 2013 however this is not the basis of this Domestic Homicide Review and Overview due to the date of the commissioning of both the review and overview report and not the reporting date.

1.6 The scope of the review

1.6.1 The review will:

- Seek to establish whether the events in 2012 could have been predicted or prevented.
- Consider the period of 7 calendar years prior to the events, subject to any information emerging that prompts a review of any earlier incidents or events that are relevant (from the 1st January 2005 to the date of death).
- Request Individual Management Reviews or reports where appropriate, by each of the agencies defined in Section 9 of the Act, and invite responses from any other relevant agencies or individuals identified through the process of the review.
- Seek the involvement of the family.
- Take account of the coroners' inquest in terms of timing and contact with the family.
- Produce a report which summarises the chronology of the events, including the actions of involved agencies, analyses and comments on the actions taken and makes any required recommendations regarding safeguarding of families and children where domestic abuse is a feature.
- Aim to produce the report in accordance with the timeline as agreed at panel meetings, respond sensitively to the concerns of the family, particularly in relation to the Inquest process, the individual management reviews being completed and the potential for identifying matters which may require further review.

1.6.2 In addition the review will seek to involve the family of the victim and the perpetrator in the review process, taking account of who the family wish to have involved as lead members and to identify other people they think relevant to the review process.

1.6.3 We will seek to agree a communication strategy that keeps the families informed, if they so wish, throughout the process. We will be sensitive to their wishes, their need for support and any existing arrangements that are in place to do this.

1.6.4 We will identify the timescale and process of the Coroner's Inquest and ensure that the family are able to respond to this review and the Inquest without undue pressure.

1.7 Subjects of the review

1.7.1 The victim of this review is Adult A who on the date of her death was aged 55yrs.

1.7.2 The perpetrator is identified as Adult B. He is the natural son of the victim.

1.7.3 Adult A suffered from multiple sclerosis and was wheelchair bound. She was cared for at home by her partner Adult C.

1.8 Objective of the review

1.8.1 The purpose of a Domestic Homicide Review (DHR) is to give an accurate account of an agency's response to Adult A: to evaluate that response and if necessary to identify any improvements for future practice.

1.8.2 This overview report is based on the information provided by professionals who are independent, having no involvement with the victims, family or the alleged perpetrator. Any actions will be recorded by individual agencies and strategic actions will be coordinated into a single strategic action plan that will be monitored by the Safe Durham Partnership.

1.8.3 Whilst key issues have been shared with organisations the report will not be disseminated until appropriate clearance has been received from the Home Office Quality Assurance Group. 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 the Safe Durham Partnership Board. The associated reports from agencies will not be individually published. The publication of this overview report will be timed in accordance with the conclusion of any related proceedings and any other review process, and after the appropriate clearance from the Home Office Quality Assurance panel. The DHR overview report will be made public and the recommendations will be acted upon by all agencies, in order to ensure that any lessons of the review are learned.

1.8.4 Relevant family members of the adults will be briefed about the report in accordance with policy and practice of the Safe Durham Partnership Board and such consultation should take place prior to publication of the report.

1.8.5 The overview author is conscious that this report may contain some upsetting and distressing information for the family of the deceased and care will be taken to ensure that any concern will be addressed accordingly.

1.9 Background

1.9.1 In 2011 and 2012 a total of 540 murders were committed in England and Wales. Of these 176 were identified as being 'domestic homicides'[3]. Historically, very few domestic related homicides were reviewed leaving a potential gap in professional's knowledge. In 2011 the Home Office published the Multi-Agency Statutory Guidance for the conduct of Domestic Homicide Reviews. The legislation became effective as of April 11th 2011.

[3] In accordance with the definition of a 'domestic homicide' at that time.

1.9.2 The Safe Durham Partnership was formed in April 2009 following Local Government reorganisation. Prior to this there was a long history of partnership working across County Durham at both a countywide level and through the five districts/borough based Community Safety Partnerships[4]. The vision is for a County where every adult and child will be, and will feel, safe. Working in partnership is essential to achieving 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 their communities[5].

1.9.3 Crime in County Durham is currently at its lowest levels since 1983 and has a crime rate well below the average for England & Wales. Repeat victimisation rate for domestic abuse remains well below the target set by the Home Office. Levels of domestic abuse related incidents reported to the police have remained relatively stable with 10,209 incidents in 2009/10, 10,425 in 2010/11, 10,865 in 2011/12, and 11,084 in 2012/13.

1.9.4 The Safe Durham Partnership is committed to preventing crimes against vulnerable people, but where they do occur it will provide them with 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 in 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 across all of County Durham. The Partnership is committed to creating a culture where domestic abuse victims have the information and confidence to ask for help.

1.9.5 Alcohol harm reduction is also a priority for the partnership. Alcohol was identified as a significant factor that cuts across all other priorities. Alcohol and substance misuse are problematic in their own right and 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. Within the Safe Durham Partnership Plan for 2011-14 are two areas that are of particular relevance to this review:

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

1.9.6 It is because of the strong commitments and clearly 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 DHR will be acted on accordingly.

[4] Although CSP's continue to exist, this process will be reviewed by the respective PCC's.
[5] Safe Durham Partnership plan 2011-2014

Section 2: The Facts

2.1 Case specific background

2.1.1 The victim, Adult A, was 55 years of age at the time of her death. She had suffered from multiple sclerosis for a number of years and had limited mobility which was to an extent alleviated by the use of a wheelchair. Adult A lived with her partner of some 26 years, Adult C, who was also her primary carer, although Adult A had other support from independent carers, some of whom had been working with her for a number of years.

2.1.2 Adult A had regular contact with her 34 year old son Adult B, who lived in the same small market town located in the heart of County Durham.

2.1.3 In 2012, Adult B collected Adult A on the pretext that he was taking her out for lunch. Adult B used the mobility vehicle of Adult C which was specially adapted for her wheelchair in that access was at the rear of the vehicle and Adult A would be transported using the wheelchair, facing the direction of travel and secured to the inside rear of the vehicle.

2.1.4 Adult B was assisted by Adult C to secure Adult A's wheelchair and he then drove Adult A to a secluded wooded area close to their homes. He then shot the victim with a shotgun, which he had unlawfully obtained. Adult B then telephoned the police stating that he had shot and killed Adult A and gave his location. Before the police arrived he also shot his pet dog, before turning the gun on himself. This all occurred within the space of some 20 minutes of having collected Adult A from her home.

2.1.5 The perpetrator had left a note to his previous partner, Adult P, along with some money, stating that he could no longer bear to see his mother as she was. He had delivered this to her address at some stage prior to the tragic events. Evidence presented to the Coroner's Inquest indicated that he had practised writing a number of notes in the time leading up to the events.

2.1.6 Adult B rarely took the victim out and, it was reported that Adult A was looking forward to the planned time with her son. Although she suffered from severe multiple sclerosis, she was described by those who knew her as being full of life and she seemingly complained little about her illness.

2.1.7 In the transcript of the telephone call made by Adult B in what is understood to have been the immediate aftermath of the murder of Adult A, Adult B referred to his dislike of Adult A's condition. The overview report does not intend to rehearse the comments made within the transcript, which was read at the Coroner's inquest.

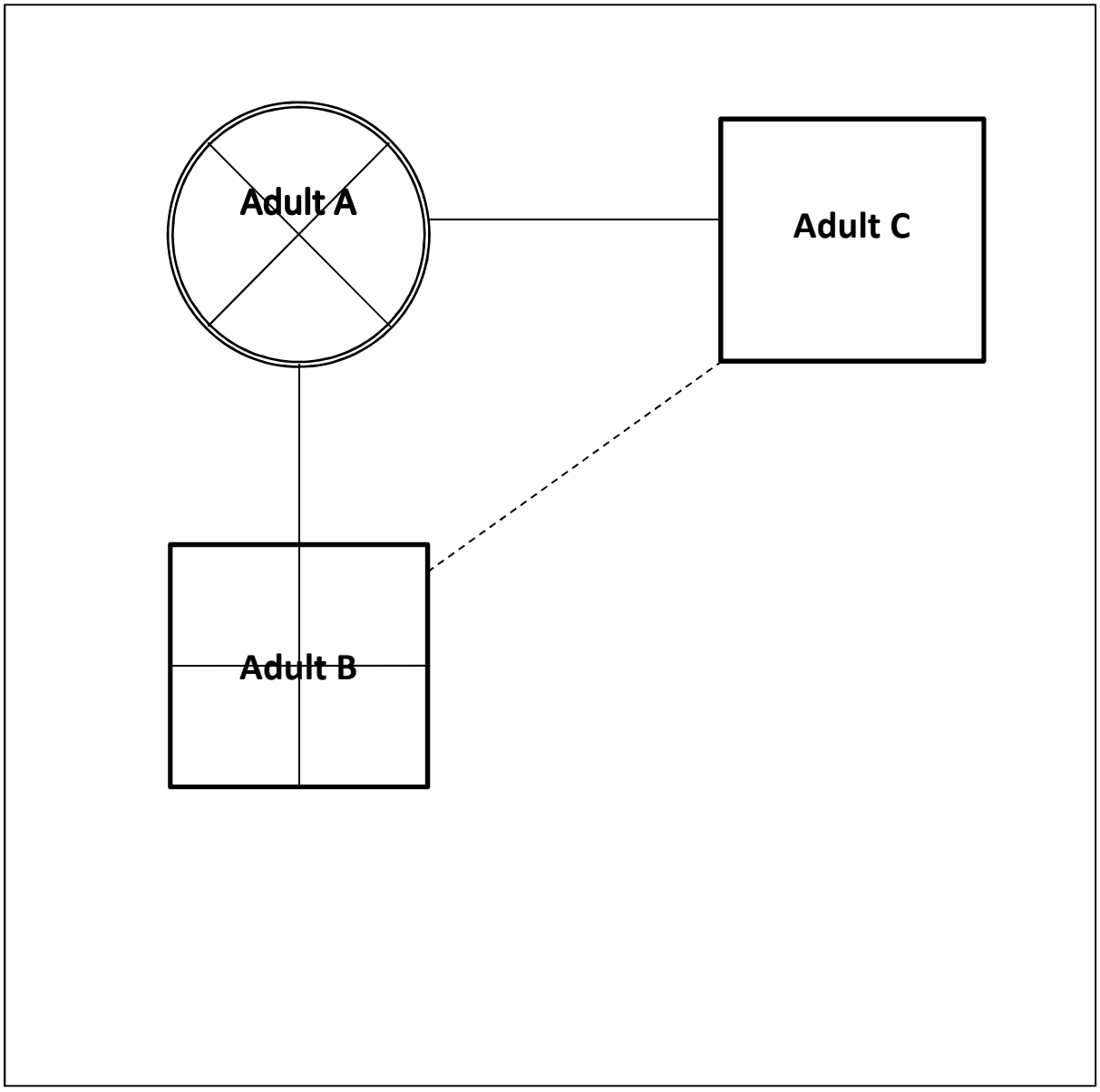
2.1.8 The Chair of the panel has had contact with Adult C who has gratefully accepted the consultation, however he doesn't believe there is anything to learn or has anything

to say that could add any value to the background. The overview acknowledges this perspective and sympathises with this decision.

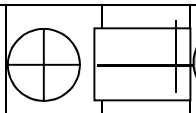
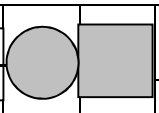
2.2 Chronology

2.2.1 The overview author is grateful for the chronologies submitted by the respective agencies which have assisted in the compilation of this report. The respective chronologies are not reproduced for the purpose of this overview report.

2.3 Genogram



A Genogram is a way of representing a family tree and relationships within the family.
Key:

			X			———	Enduring Relationship
						- - - -	Transitory relationship
Female	Male	Pregnancy	Abortion or Miscarriage	Deceased – Cross is placed inside gender symbol	Subject	/	Separation
						//	Divorce

2.4 The Individual Management Reviews (IMR)

2.4.1 In this case the panel has not commissioned any IMRs from any of the identified agencies, due to the circumstances of the case. The panel chair reviewed the information submitted by each agency relating to their involvement. At the panel meetings each chronology was reviewed. There was very limited involvement of all the agencies. Each of the agency's involvement was reviewed in turn and it was agreed by the panel and the chair that there would be no benefit in completing a full IMR due to the lack of involvement of the agencies.

Therefore, reports and chronologies form the basis of the information provided by all involved agencies. The Chair of the panel has also made personal contact with the partner of the victim, who does not wish to add any comment to the process. A long-term carer of the victim was also contacted and felt she was unable to assist with any background information.

2.5 Summary of facts in the case

2.5.1 The police investigation concluded that Adult A was murdered by Adult B in 2012. There was no evidence of any third party intervention. There is no evidence obtained as a result of the police investigation that could have predicted the immediacy of the events on that particular day. Durham Constabulary conducted a murder enquiry with the resulting evidence being presented to HM Coroner in order to rule accordingly.

2.5.2 The Coroner's investigation and report were concluded before the start of this domestic homicide review on 27th November 2012. There was therefore no requirement to discuss the undertaking of this review with the Coroner. The Coroner in his summing up in recording a verdict of unlawful killing of Adult A by Adult B and in ruling that Adult B took his own life, commented,
"There could be no objective justification whatsoever for what was done that day."

2.5.3 Adult B was the natural son of Adult A. At the time of the tragic events, Adult B was 34 years of age. There is no information concerning his natural father.

2.5.4 The family background suggests that Adult B knew little of his natural father, had no contact with him during his formative years and felt isolated as a child and a 'strained' relationship with his mother. In 2009, it was recorded that he had a sister, whom he had had no contact with at the times of the death for some 7 years. However there is no detail of his sister within the records examined by the overview author, and Adult C didn't mention her.

2.5.5 Adult B had no apparent history of violence.

2.5.6 Adult B had a past history of heroin addiction but he had overcome this with appropriate medical intervention and support. His heroin addiction dated back to 2003 and he was treated with Methadone, there is no record of when this treatment stopped, with no other reported issues. Although this is outside of the terms of reference, the overview author considers that this contextual information is important when considering how or why Adult B acted as he did. This may be of relevance given that the forensic pathology revealed traces of both illegal and legal drugs in Adult B, suggesting that he was using unlawful drugs in the period preceding the tragedy.

2.5.7 There was increased involvement with Adult B's GP from September 2008 when he was reported as suffering from anxiety and depression. He was referred to see a consultant psychiatrist but only attended the one appointment in December 2008. The Tees Esk and Wear Valleys NHS Foundation Trust's records indicate that Adult B was suffering from a mixed anxiety and depression. The risk of self-harm or suicide or harm to others was reported as being *"negligible at present".* A further appointment was made in order to assess a possible anti-social personality trait.

2.5.8 The GP records indicate that Adult B was seen seven times by his GP practice between September 2008 and December 2008, where he was treated for low mood and depression. During this time Adult B reported having hallucinations, paranoia and anxiety. He was treated with prescribed medication of Mirtazapine and Lorazepam[6] during this period.

2.5.9 There was nothing in Adult B's GP records to indicate that he was violent or had thoughts of harming himself or anyone else of either a recent or of an historical nature.

2.5. By May 2009, Adult B reported that he no longer wanted psychiatric support and he cancelled an appointment with the psychiatrist. As a consequence he was discharged. From therein up until the point of the notification of his death, there are no other relevant GP records concerning Adult B.

2.5.11 By the time the GP saw him in February 2009, it was reported that he was feeling better, had stopped his medication and was actively seeking work. He did not wish to see the psychiatrist further. He failed to attend his psychiatric appointment in April 2009 and in

[6] Lorazepam belongs to a class of medicines called benzodiazepines. It is a medicine which is used to treat anxiety or anxiety due to sleeping problems or other psychiatric problems. Mirtazapine is generally used to treat major depressive and mood disorders but can also be prescribed to assist in generalised anxiety disorders and sleep apnoea.

May 2009 Adult B was discharged following contact with him, indicating that he did not wish to have any further appointments.

2.5.12 The victim, Adult A was medically diagnosed as having Multiple Sclerosis. There is no indication of when the victim was initially diagnosed with the illness, although it is acknowledged that by its very nature the condition is chronic and progressive. Medical records acknowledge Adult A's regular contact with her GP, but otherwise it is not of any note and concerns only the physical symptoms of her MS condition.

2.5.13 There is no reference to any suggestion that Adult A was suffering from any form of mental health or presented any risk to herself or others.

2.5.14 There is no indication from the GP report that she was at or felt at risk of harm from Adult B.

2.5.15 The police have recorded a number of minor matters of contact with Adult B. Ostensibly this contact in the main was when Adult B was either on his own or in the company of others, on occasions with his dogs and is centred around potential poaching and what would appear to be in pursuit of game, once with the land-owner's permission. None of the instances is of any apparent significance and no issues are raised from the interaction between officers and Adult B or any of his associates. None of the occurrences appear to have involved firearms.

2.5.16 Adult B has two convictions for minor offences within the review period, although he has a criminal record extending back a number of years. In respect of the recent record, in June 2008, he was convicted of a minor Theft Act offence, for which he was fined and in March 2011, he was arrested for interfering with a badgers set in North Yorkshire. For the latter offence he received a community punishment order in November 2011.

2.5.17 There is no indication that within any of the interactions with the police was there any mention of the use of, or possession of a firearm, which is frequently associated with 'countryside' matters.

2.5.18 There is no indication from Durham Constabulary, that Adult B was of any particular concern to them and there is no adverse inference from their contact and engagement with him.

2.5.19 In respect of the conviction for interfering with a badger set, Adult B received a community punishment of 100 hours unpaid work. The issue identified by the Probation report is the fact that Adult B was sentenced without a Standard Delivery Report[7] and as a

[7] These types of report are requested for medium and high seriousness cases. The Offender Manager will complete a full assessment on the offender using a comprehensive assessment tool for these reports. They are required when the Court is considering a possible Community Order or Custodial Sentence. These reports all provide information about the offender as well as detail of the offence, any circumstances surrounding the offence. An assessment of the level of risk that the offender poses to the public the likelihood of re-offending Suggestions of an appropriate sentence. The sentencing Court takes all this into account prior to making the final sentencing decision.

consequence the Durham Tees Valley Probation Trust (DTVPT) knew little about the individual, background and antecedents. This type of report is generally ordered and completed by the respective court ahead of the actual sentence.

2.5.20 The record of Adult B's attendance for unpaid community work is unremarkable up until February 2012, when Adult B refused to wear safety boots and was sent home. Prior to this point, he had been absent on two occasions and following this he was also absent on two further occasions, citing illness. Although the probation service can make home visits, there was no requirement to do so and no other adverse issue was raised about his attitude to work.

2.5.21 Adult B was still in the process of his unpaid community work at the time of the murder although he had attended as normal throughout 2012, where no issue concerning him was made or observed by the supervising staff.

2.5.22 In respect of the victim, Adult A, there is relatively little documented information available from the respective agencies.

2.5.23 Within the information provided by the Durham County Council Adult Care, Social work staff had regular contact with Adult A between February 2008 and April 2012. Adult A was seen on each occasion and there was also regular contact with Adult C from both social work and occupational therapy staff. The records provided from them indicate that there was *"no evidence of periods of low mood".*

2.5.24 Between December 2008 and March 2012, six social care assessments were carried out in respect of Adult A by adult care. The records indicate that there was *"some low mood due to health implications on her life that her health poses*". This was managed through her social outlets and *"regular visits by the family, including her son"*

2.5.25 Adult A had her last social care assessment in April 2012.

2.5.26 All of the social care assessments were carried out in person with Adult A and were conducted in a cycle of a six-monthly re-assessment of her needs.

2.5.27 Adult A received direct payment funding in order to support her personal care needs and attended a day centre, one day a week. It is also recorded that she had respite care on occasions which included a short break with her carers.

2.5.28 It was reported at the Coroner's Inquest that although Adult A suffered from Multiple Sclerosis that she dealt with her condition remarkably well. A quote from the investigating police officer at the hearing was that *"Although the physical effects of her illness were quite marked, she was coping well, was upbeat and approached her illness with good humour."* Adult A relied on her wheelchair for mobility.

Section 3: Analysis

3.1 Family involvement and perspective

3.1.1 The Chair of the DHR panel met Adult C the partner of Adult A. He commented that he was grateful for being consulted and was content with the terms of reference for the review. Adult C was naturally emotional in respect of the contact and he did not believe that he had anything to add or that there was anything to learn from the tragedy.

3.1.2 Through the Family Liaison Officer, the Chair also contacted through the FLO a long-term carer of the victim, who did not attend a meeting as she felt that she had nothing to add that was not already known and that there was nothing to learn in addition.

3.1.3 The overview author has considered matters at the Coroner's inquest held in November 2012 and notes comments made during the hearing. It was indicated by Adult C that Adult B would visit Adult A *"Once or twice a week"* but would only stay a short time and had no involvement in her care.

3.1.4 The medical evidence presented at the hearing in respect of Adult B found 'trace' amounts of cocaine and an 'ecstasy like drug' as well as prescription medication that he was taking for his epilepsy. The forensic pathologist commented that, *"'He may well have been experiencing the effects associated with those drugs prior to his death".* This was not explored in any detail during the Inquest.

3.1.5 Although Adult B left a note at the home of his estranged partner, Adult P, there was no evidence presented to the hearing that gave any indication of Adult B's preparation and planning, although his acquisition of the firearm and ammunition must have taken place sometime before the day in question. The police investigation concerning the weapon was unable to identify the origins of the weapon or the source for Adult B's possession or when he may have taken possession of it.

3.1.6 The information for this overview report from Adult P, the estranged partner of Adult B, is that although she thought that he was worried about his mother's health but there was no indication that he was going to do anything to her.

3.1.7 There is no information concerning the sister of Adult B and the family hadn't had contact for 7 years with her.

3.1.8 The overview author has not seen any evidence or information that the ethnicity or cultural background of either the victim or the perpetrator has any relevancy to the circumstances of this case. The overview author is satisfied that these issues have been adequately addressed within the relevant reports.

3.1.9 There were a number of friends of Adult B that were contacted through the police for the inquest including the one that he made the comment to *'"You would not keep a lurcher like that. If you kept a dog like that you would get done off the RSCPA",* when referencing

Adult A's condition. A number of these friends he was with the night before and also saw one of them on the morning of the deaths they all thought he was his normal self and he did not do or say anything that would have given them any cause for concern for him or his intended actions.

3.2 Analysis

3.2.1 This was a tragic event that has had considerable impact on the family of the deceased and those who knew and cared for her. Other than the posting of the note through the door of the previous partner of Adult B, which would appear to have happened a very short time before the events took place, the acts could not have been predicted from the information that the overview author has seen.

3.2.2 It is apparent that Adult B had clear intentions. His recorded comments and notes suggest, that it was his belief and his alone, that his mother was suffering considerably from her Multiple Sclerosis and he felt that could do nothing about this. Whether or not the effects of the drugs that were present in his body had a profound effect on him at that point can only be speculated upon. The clear and intentional act was the acquisition of the weapon and the relatively small timeframe in which he carried out the murder having collected Adult B on that morning.

3.2.3 There is information and records that indicate that Adult B had suffered from psychological episodes over a number of years, but he did not attend appointments. These episodes do not appear to have been investigated thoroughly due to his refusal to attend appointments. It is possible that the refusal by Adult B to undertake any systematic treatment or therapy was hampered by his social isolation. This was commented upon by a psychologist in 2008/9, but not explored further due to the reluctance of Adult B to continue with his therapy.

3.2.4 The issue of missed appointments was reviewed by the panel. In this case, it is clear from the information provided that Adult B's psychiatrist made contact in order to encourage him to attend for further appointments. There was, however, a missed opportunity for the GP to discuss the fact that Adult B was not attending appointments. However the overview author fully acknowledges that attendance or compliance will always rely on the attitude and behaviours of the patient.

3.2.5 Potentially if Adult B had attended his mental health assessments, the professionals may have gained a greater insight into him and his personality and his mental health. It is clear however that practitioners have done their best to support him, but he has simply failed to take up the professional support that he appears to have needed at that time. This may have contributed to his longer term mental health issues. It appears that Adult B was quite introverted and gave little away to those close to him.

3.2.6 Adult B appears to have concealed his mental health issues from family and friends. Adult B wrote in his suicide notes, (which were read at the inquest), that he was *"mentally unhinged" and that "It [the murder] had been on the cards for years*". As stated earlier in

this report he added to a friend *"You would not keep a lurcher like that. If you kept a dog like that you would get done off the RSCPA",* when referencing Adult A's condition. This comment may have had greater relevance had there have been other indicators within his personality that together would have raised any awareness of his intention to cause harm to Adult A. The friend never shared these comments with anyone until after the events.

3.2.7 The social care assessments made in relation to Adult A comment on the support for her 'low moods' that she received from her family and her son. It was stated by Adult C during the Coroner's Inquest, that Adult B actually rarely visited his mother. It is possible however that the interaction between Adult B and Adult A was of greater personal significance than was realised or understood by others. Whilst this is speculative, the level of confidence between the two of them as mother and son could have contributed to the manner with which Adult B viewed his mother's condition or with which she confided in him.

3.2.8 The acquisition of the shotgun by Adult B is a matter that was thoroughly investigated by Durham Constabulary within the murder investigation. Despite significant enquiries, the weapon could not be traced back to an earlier 'lawful' possession by an individual or group. It is an acknowledged fact that despite the high levels of safety and security employed in the acquisition and possession of firearms, such weapons continue to be available and not just purely for criminal use. It is conceivable that Adult B was able to obtain the weapon through his hunting and gaming interests, where it is known that shotguns and firearms are illegally held and used.

3.2.9 There is no record of Adult B having applied for a shotgun certificate or a firearms licence or having been the lawful holder of any firearms at any time. He had no convictions for firearms offences and in law would not have been prohibited from making an application to purchase or acquire a shotgun.

3.2.10 Adult B committed the murder within minutes of taking his mother from her home. What occurred within that interim period can only again be speculated upon; it is not known whether Adult B collected the shotgun after he had driven his mother from her home, or it was retrieved and concealed by him close by the scene of the offence, an area that he apparently knew well.

3.2.11 Adult B was killed whilst remaining in her wheelchair in the rear of the vehicle. This whole scenario appears to have been planned and executed in a short space of time and without the police being in a position to attempt to negotiate with Adult B, who then also took his own life following the telephone call to them.

Section 4: Conclusions & Recommendations

4.1 Conclusions

4.1.1 This is a particularly tragic case where there was no apparent indication of the intentions of the perpetrator, or the risk that he posed to the victim. The 'build-up' to the events was in a minimal time-frame that could not have been anticipated by others. The only exception to this may be in respect of the perpetrator's acquisition of the firearm, although it is unlikely that those who supplied the weapon would have had knowledge of the user's intentions.

4.1.2 From the records available, it is fair to assess that Adult B appeared to have posed a potential greater risk to himself rather than others, although his refusal to attend further psychiatric appointments in early 2009, did not assist in health practitioners identifying any underlying disorder or concern. He appears to have used unlawful drugs shortly before the tragic events.

4.1.3 This is not the first occasion that DHRs have been presented with evidence of perpetrators of violent crimes and homicides failing to attend professional medical appointments. Does the fact that they fail to attend shield deeper emotions and anxieties and is there an opportunity to further engage with them? It is fundamentally difficult for practitioners to make progress with their patients where they fail to engage, and not attend appointments. It is an individual adult's right to engage with treatment or not as they wish. Nonattendance is perhaps something that professionals may be able to explore by way of a 'trigger' within the individuals medical records that can be shared accordingly by professionals to signpost potential concern.

4.1.4 Adult A was known to have had several carers, some of whom were reportedly longer term carers. Where there are long term carers that know a patient well, it may be helpful to ask their views when assessing how a patient is coping with a long term condition. This is particularly of relevance where the core of the assessment is based upon physical condition, as opposed to any mental health assessment. Significant physical conditions may hide an underlying mental health issue. Those having regular and repeated contact with the patient are generally those who make sound judgements and are best placed in identifying any change in the service user's behaviour.

4.1.5 The Probation Service observation in their report for the DHR that a Standard Delivery Report was ordered in respect of Adult B by the relevant court, is noted. However the decision not to ensure that such a report was used as part of the sentencing by the relevant Justices is a subjective matter and should therefore be addressed by the respective Senior Clerk to the Justices. This is a matter that is outside of the reviews remit and terms of reference, however this procedural matter should be addressed accordingly. It is implied with the probation report that without such information, very little was consequently known about Adult A and it is the overview author's perspective that this is a risk, which must be addressed. However in order to clarify this position, the sentencing court should be

asked to review the circumstances and identify if such action should have occurred by reporting directly to the SDP.

4.1.6 It is the overview author's considered opinion, based upon the information seen, that this is a case where it could not have been predicted that the perpetrator would have carried out such tragic acts of violence.

4.1.7 This overview report will be shared with Durham's Children and Adult Safeguarding Boards for them to ensure relevant issues and learning are taken forward.

4.2 Recommendations

4.2.1

Recommendation 1:

The Safe Durham Partnership to ensure that health providers in County Durham review their DNA policy and make sure that it is being appropriately applied.

This is to ensure that health professionals highlight patients who repeatedly do not attend (DNA) for medical appointments and ensure that this information is shared with practitioners in order to address the individuals needs and if other interventions are possible in order to encourage attendance and treatment.

4.2.2

Recommendation 2:

The SDPB to ensure that included within the Carers Strategy guidance to not only health providers but also to social care and the voluntary sector that they ask questions from those carers that are regularly engaged as part of the on-going care of a patient and they are encouraged to make comment concerning the patient as part of the on-going assessment plans.

This may identify any underlying trend not identified as part of any generic assessment process.

4.2.3

Recommendation 3:

The SDP asks the Durham and Darlington Sentencing Liaison group to review the rationale for adjourning a case for a Standard Delivery Report; this was not actually addressed as required when the perpetrator was sentenced without completion of this by the Justices.

It is implied within the probation report that without such information, very little was consequently known about Adult B when he appeared at court and it is the DHR panels perspective that this is a risk, which must be addressed accordingly.

4.2.4

Recommendation 4:

That Durham Constabulary considers the opportunity to lead a partnership approach to a 'weapons amnesty' in its force area in order to reduce the number of illegally held weapons in particular firearms.

This case can be used to 'market' the approach to the community. Such amnesties are known to be successful in the anonymous surrender of a range of weapons which could otherwise come into the possession of individuals.

4.2.5

Recommendation 5:

The SDP considers as part of its integrated multi-agency training plan, awareness training for agencies and health providers that care for or have regular contact with persons with long term and debilitating illnesses that they are mindful of the effects that this may have on their families.

It is hoped that this recommendation will alert practitioners be they statutory or private, adult social care and the voluntary sector to the risks posed to family members by the impact of living with patients who have long term and debilitating illnesses. Also, it is hoped to ensure that agencies are able to offer and provide leaflets/advice/signposting for the family members' and friends' welfare.