Domestic Homicide Review

South Lakeland Community Safety Partnership

Mark Yexley April 2014

OVERVIEW REPORT

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Overview Report

Introduction

1. On 21 August 2012 ambulance services and police were called to a remote farmhouse in Cumbria the home address of Sarah, a 77-year-old woman. On arrival they found Sarah dead. They had been called because Sarah's son, John, had told his partner Debbie that he had killed his mother and Debbie then found her body. Cumbria Constabulary commenced a homicide enquiry and John was arrested later that night. John later stood trial for murder and was found not guilty. He pleaded guilty to Manslaughter on the grounds of diminished responsibility and in May 2013 he was sentenced to 13 years imprisonment at Preston Crown Court.

2. These events led to the commencement of this Domestic Homicide Review (DHR) at the instigation of the South Lakeland Community Safety Partnership (CSP). The initial meeting was held on 29 January 2013 and there have been three subsequent meetings of the DHR panel to consider the circumstances of this death.

3. The DHR was established under Section 9(3), Domestic Violence, Crime and Victims Act 2004.

4. The purpose of the review is to:

- Establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims
- Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result
- Apply those lessons to service responses including changes to policies and procedures as appropriate
- Prevent domestic homicide and improve service responses for all domestic violence victims and their children through improved intra and inter-agency working.

5. This review process does not take the place of the criminal or coroners courts proceedings nor does it take the form of any disciplinary process.

6. Terms of Reference

7. The full terms of reference are included in Appendix 1. The essence of this review is to establish how well the agencies worked both independently and together and to examine what lessons can be learnt for the future.

8. Methodology

9. The approach adopted was to seek Individual Management Reviews (IMRs) from all organisations and agencies that had contact with Sarah or John. It was also considered helpful to involve those agencies that could have had a bearing on the circumstances of this case, even if they had not been previously aware of the individuals involved. Details of those agencies providing IMRs or summaries of information held are outlined in the terms of reference.

10. Once the IMRs had been provided panel members were invited to review them all individually and debate the contents at subsequent panel meetings. This became an iterative process where further questions and issues were then explored. This report is the product of that process.

11. Composition of the DHR panel

- Crown Prosecution Service
- Cumbria Alcohol and Drugs Advisory Service (CADAS)
- Cumbria Constabulary
- Cumbria County Council Adult Social Care
- Cumbria County Council Children's Services
- Cumbria County Council Community Safety
- Cumbria Partnership NHS Foundation Trust (CPFT) – Mental Health Services
- Impact Housing and Let Go Domestic Violence Project
- NHS Cumbria Clinical Commissioning Group Primary Care
- South Lakeland Community Safety Partnership (minutes and administration)
- South Lakeland District Council
- Standing Together (Independent Chair)
- Unity Greater Manchester West Mental Health Trust
- University Hospitals of Morecambe Bay NHS Foundation Trust (UHMBT)

12. The panel included third sector representatives. CADAS provide local services for substance misuse and also were the agency who had contact with the perpetrator shortly before the homicide. The Let Go Domestic Violence Project represented local domestic violence services. In addition to the panel members there was further consultation with Age UK in reviewing the report and advising on recommendations. The contribution from all third sector agencies was a crucial part of the process. A full list of panel members is contained in Appendix 2.

13. To assist this review the chair made contact with the family of Sarah. The panel nominated the victim's daughter, Claire, as the most appropriate person to contact. She provided a valuable insight into the dynamics of the family and interaction with the community and statutory services. Attempts are being made to contact the partner of the perpetrator, but she has now moved away from the area. It was decided to delay contact with the perpetrator until the criminal prosecution had concluded. The chair has interviewed the perpetrator in prison, after his conviction. John provided information concerning his state of mind and what he believed triggered the argument with his mother immediately before the homicide.

14. The independent chair of the DHR is Mark Yexley, an ex-Detective Chief Inspector in the Metropolitan Police Service and a lay chair for NHS Services in London, Kent, Surrey and Sussex. Mark represents Standing Together Against Domestic Violence, an organisation dedicated to developing and delivering a coordinated response to domestic violence through multi-agency partnerships. He has no connection with Cumbria County Council or any of the agencies involved in this case.

15. The process took some time to complete before full submission to the Home Office Quality Assurance panel. The case was initially delayed to allow the full details of the case to come out from the criminal trial process. The panel were not aware of representations made by the perpetrator regarding his mental health until after the trial process. The decision to wait for the trial to finish proved valuable. The process was further delayed as it took some time for the chair to establish contact with the

victim's family. After some time the perpetrator consented to interview, but this was not completed until January 2014. The delays in publishing the report did not delay any actions on internal or cross agency recommendations.

16. There have been no parallel or similar reviews conducted into this case.

The Facts

17. The death of Sarah

18. The victim, Sarah, was killed by asphyxiation on 21 August 2012 in her family farmhouse. She was 77 years old at the time of her death. The circumstances leading up to her death are as follows.

19. Sarah was a retired vet residing in a remote rural community. She lived alone in a two-bedroom farmhouse. Sarah had two children, a 52-year-old daughter Claire and a 48-year-old son John, the perpetrator. Sarah's son and daughter lived in other premises, part of the farm property, close to the farmhouse. Claire lived in a separate converted barn on the farm site, with her husband and children. John lived with his partner Debbie in a caravan sheltered under a barn on the property. John and Debbie would use toilet and cooking facilities within Sarah's farmhouse.

20. The victim Sarah had not reported any concerns to agencies about her son before her death. Debbie had recently sought help for problems with alcohol misuse by John from Cumbria Alcohol and Drugs Advisory Service (CADAS). Debbie attended the appointment accompanied by John, both reported drinking heavily and they were referred to seek individual help. There were no concerns of domestic abuse raised at the appointment.

21. Debbie later told police that about six weeks before the death of Sarah she was woken in the middle of the night, by John standing over her with a knife. Debbie told police about this incident after the homicide, she had not previously disclosed this to any agency.

22. On 21 August 2012 at 22.00 hours the ambulance service received a call, to the home of Sarah, where it was reported that a male in an alcoholic rage had attacked a female. John had told Debbie that he killed his mother and Debbie had found the body Sarah of in her bed. The ambulance services attended the scene and located the body of Sarah and commenced CPR, but she was pronounced dead. Cumbria Constabulary were called and a homicide investigation was commenced. After a helicopter search of the area John was arrested.

23. A post-mortem examination was conducted on Sarah and it was revealed that she died through asphyxiation, probably by hand.

24. On 23 August 2012 John was charged with the murder of Sarah. He later pleaded not guilty to murder and was found not guilty. John pleaded guilty to a count of manslaughter and was sentenced to 13 years imprisonment.

25. An inquest was opened at Kendal Coroners Court. After John's criminal conviction the coroner recorded cause of death as asphyxiation on 11 June 2013.

26. Sarah contact with statutory sector

27. Sarah and her family lived in a remote area. They were rarely visited at home by any services and would travel to local appointments when required.

28. The only recorded contact for Sarah with any statutory bodies comes from her time as a patient with her small rural NHS General Practice. Sarah had been seen by her General Practitioner (GP), with minor self-limiting conditions and some recurrent shoulder problems, for which she received assessment and treatment at University Hospitals Morecambe Bay. She attended all appointments for routine vaccinations and screening. Her GP was of the opinion that Sarah was able to treat herself for minor ailments due to her profession as a vet.

29. On 18 August 2012, three days before her death, Sarah attended her GP where she was treated for neuropathic pain and a diagnosis of shingles was made. Sarah was examined by her GP and there were no concerns or any other issues raised by her.

30. It is believed that Sarah felt able to report family problems to her GP. She had previously reported concerns about stress in a family relationship outside the terms of reference of this report, some years ago. It is appreciated that it would not naturally follow that she would report if she were herself a victim of domestic abuse.

31. The perpetrator - John

32. The main areas of contact between local services and John came through incidents reported to the police and visits to the local GP practice, where Sarah was also a patient.

33. John was known to the police from 1987 when he was arrested for hitting a person with a crowbar. He was convicted of an offence of wounding and given a financial penalty. The nature of the relationship between John and the victim of that offence is not known. John had not been subject of any criminal convictions between that date and the homicide. He did come to police attention for drugs offences.

34. John was known to be living at his mother's farm in 2005. Police were called to the farm over an allegation that he had assaulted his niece. The incident arose when John and his niece were separating two fighting dogs and she was injured. Police investigated the incident and there was not found to be any evidence of assault. During the investigation a crop of cultivated cannabis was discovered and John was arrested. He was later cautioned for the cultivation and was offered self-referral to a drug and alcohol abuse scheme as part of the police custody procedures. There is no information available on the outcome.

35. During 2005 there was also a breakdown in the relationship of John and his partner of that time. There was no reported domestic abuse.

36. In 2007 John commenced a relationship with Debbie. She resided in central England and they travelled to see each other. Neither Debbie nor John were in full time employment and they did not claim state benefits.

37. On 10 June 2009 police were called to the home of Claire, sister of John. She reported to police that John was drunk and had tried to get hold of her outside her house. Their mother, Sarah, was present at the incident. At the time Claire expressed concerns on her brother's escalating strange behaviour. The incident was recorded by police as a verbal argument. The incident was risk assessed by the police public protection unit and no further action was taken against John. Under the domestic violence policy of the time this was considered a 'bronze' response that resulted in a letter being sent to Claire offering her support and a point of contact if required.

38. On 22 January 2010 John re-registered with the local GP practice. John informed his GP that he was drinking heavily and that he had been encouraged to see his doctor by his mother. He reported that he had been drinking a bottle of whisky most nights

for two years and he had been a heavy drinker before that. After an initial assessment the GP used the Alcohol Use Disorders Identification Test (AUDIT) and John was assessed as being alcohol dependant. Further medical tests revealed liver function to be good considering his level of dependency. His GP talked through strategies to reduce alcohol intake and provided John with details of Alcoholics Anonymous (AA) and CADAS. He did not make any contact with CADAS.

39. On 19 January 2011 John visited his GP with another medical condition. There was no mention of alcohol dependency at this consultation.

40. In March 2012 Debbie commenced living with John, moving into his caravan at Sarah's farm. On an unknown date in early July 2012, Debbie was asleep in their caravan when she was woken in the middle of the night. She found John standing over her with a knife; he told her that he did not kill her as a sign of his love for her. This information came to light from the police IMR and homicide investigation. Debbie confirmed that she had had a sometimes violent relationship with John; she had not received injuries and had bitten him. Debbie stated that she had not reported any concerns about John to any agency, but she had told a friend.

41. In July 2012 Debbie contacted the local drugs and alcohol advisory service, CADAS, as she had concerns about her partner's alcohol consumption and the effect on their relationship. Debbie was invited in to CADAS with a view to making a care plan to refer her to a parent, carer, family support (PCFS) service.

42. When Debbie attended her appointment on 19 July 2012 she presented with her partner, John, and asked if he could join her in the appointment. During the CADAS interview the high level of alcohol consumption disclosed by both John and Debbie was discussed. It was not deemed appropriate for Debbie to be referred to the PCFS due to her own level of alcohol consumption. Both Debbie and John were advised that they could self-refer to a one-to-one psychosocial support intervention service at that time or later. They did not take up the offer for referral whilst at the CADAS office.

43. John was also recommended, by CADAS, to see his GP to advise on safe reduction of alcohol consumption. John was considered to be drinking dependently, this requires medical assessment and treatment, CADAS is not a medical service. There was no mention made by either party of domestic abuse during the CADAS appointment.

44. On 21 August 2012 John killed his mother Sarah. He was arrested shortly after and found to be intoxicated.

45. On 22 August 2012, whilst in police detention, John was seen by a Forensic Medical Examiner (FME) and referred to the Crisis Intervention Assessment Team (CIAT) for mental health assessment. John told the CIAT that he had been drinking for 20 years and recognised that he had a problem. He was drinking up to eight pints a night and reported that he had sought assistance from CADAS. He said that on the day of the incident he said that his mother was nagging him and he 'lost it' and killed her. He was not assessed to be mentally ill. He was diagnosed to be alcohol dependent and experiencing withdrawal. No mental health follow up was required.

46. As the final element of the DHR process the perpetrator was interviewed by the independent chair. John stated that he had lived at the same premises as his mother for 20 years and there was no violence between the two parties until the date of the homicide. He said that there was hostility between him and his sister. The perpetrator had not initiated any contact with support agencies. He had accompanied

his partner to a CADAS meeting but had not had chance to take his next steps before the death of his mother. He said that the incident leading to his mother's death was sparked her booking him into a private rehab centre. He had been drinking heavily before the argument started with his mother. He was asked if anything could have prevented the incident. He did not feel there was any negligence on behalf of any agency. His only comment was that if a person volunteers that they have substance misuse problems, agencies should follow that up. He clarified that this was making the link to his first referral some seven years ago.

Analysis

47. The following analysis examines the lives of the victim of this homicide and the perpetrator but nothing should detract from the fact that John took the life of his mother and he has been found responsible for that act. Nothing in the life of Sarah could ever possibly justify her death. It is considered that if the behaviour demonstrated by John with his partner in the months before the homicide had been communicated to responsible agencies, then steps would have been taken to assess the risk he presented to his family.

48. There is very limited information available about Sarah and John within the records of the statutory sector or third sector bodies involved in the DHR process.

49. Sarah was a retired professional woman living in a farmhouse in a remote community. Even though she was known to treat herself for minor ailments, she accessed GP services when appropriate. She visited her GP three days before her death and was examined; there was no suggestion of concern over DV raised by her. It is known that Sarah had reported family stresses in the past to her GP, but there is no evidence to suggest that she would have been aware of the threat presented by John to his partner a few weeks before.

50. There are a number of recorded incidents in relation to alcohol misuse by John. He has stated that he has been drinking for twenty years. It is not intended to analyse John's behaviour before 2009 and there is a significant gap where he was not registered with a GP before January 2010.

51. When John's sister reported a domestic incident where she was concerned about his 'escalating strange behaviour' further steps could have been taken. This could have led to further investigation, with the family or community officers, into the nature of his behaviour. This could have raised John's status to that of a vulnerable person highlighting risks. Consideration should have been given to referring John to non-police agencies with a written notification being provided to him. Written information was provided to Claire. There was however no further contact between the family and the police between this incident and the date of the homicide.

52. It appears that in January 2010 Sarah had been worried about the level of her son's alcohol consumption, but she had encouraged him to see to his GP rather than raise concerns herself. Between this time and her death Sarah had visited her GP on sixteen occasions and had not expressed any further concerns about her family. There was no evidence to statutory or third sector agencies that John was in an abusive relationship with his mother or presented a risk to her.

53. The first attempt to address John's alcohol consumption came on re-registration with his GP January 2010. A comprehensive medical history was taken with appropriate blood tests, indicating alcohol dependency. At this point the GP discussed strategies to reduce John's alcohol intake and provided him with information on third sector

agencies CADAS and AA. There was no communication by the GP to CADAS and no responsibility for CADAS to report back to a GP on their clients. John did not contact CADAS. At this point John should have been referred to statutory services for alcohol treatment provided for Cumbria by Greater Manchester West NHS Trust. A referral to the NHS alcohol service provider would have ensured that the GP was aware of any non-attendance and may have compelled John to attend appointments.

54. As a point of good practice it should be noted that the GP conducted a comprehensive medical examination including clinical tests with a quick follow up.

55. There was a further missed opportunity to check up on John's alcohol dependency. In January 2011 John attended his GP where he was examined for a medical complaint. There was no record of any discussion of the long-standing alcohol problems reported to the GP the year before and no check on whether John had taken up the previous advice. There then followed a period of eighteen months where there was no contact between John and any statutory or third sector agency.

56. John came to the attention of CADAS one month before he killed his mother. The contact was instigated by John's partner Debbie. She phoned CADAS with concerns about her partner's alcohol consumption and the effect on their relationship. Although Debbie made the appointment for herself, when she arrived at CADAS she asked if John could join her in the meeting. Consideration is given to whether a meeting with both John and Debbie present was appropriate, given that Debbie was attending to discuss her relationship. In considering this interaction there has been no suggestion by Debbie that John put her under any pressure for him to be present. During the meeting it was disclosed that both Debbie and John had been drinking heavily and it was not solely a problem with John's alcohol consumption. Given the initial call to CADAS about relationship problems the meeting could be considered as a missed opportunity for either party to discuss domestic abuse alone.

57. During this CADAS meeting both John and Debbie were advised on services where they could seek one-to-one personal support. John was advised to see his GP but there was also an opportunity to refer him to Greater Manchester West NHS Trust, the default NHS provider for substance abuse in the area. If these individual services were taken up then it may have been more conducive to disclosure by either party on the level of domestic abuse at that time.

58. During the IMR process it was revealed by police that shortly before the CADAS appointment Debbie had been woken in the night by John holding a knife. This incident may well have prompted Debbie's call to CADAS, but DV was never disclosed. Examination of Debbie's statement to the police shows that she did not disclose this incident to any statutory or third-sector agency and she only told a friend. There is no record that that information, on the risk presented by John, was subsequently passed to the police by the friend or any anonymous source. Consideration needs to be given to how public awareness of DV and third party reporting is promoted. If this incident had been reported by Debbie or her friend this would have resulted in immediate steps to assess the risks presented by John.

59. Before the death of Sarah there was no evidence within statutory agencies that she was at risk of abuse from her son John. In this case neither Sarah nor Debbie had reported any threat or violence from John to agencies that may have provided help. The panel did not feel that the risk to Sarah from her son could have been predicted, based on the information available at the time.

60. The DHR process has revealed that Sarah was very concerned for her son's welfare but was also determined to keep family matters private. The decision to admit John

to a private rehab clinic has been suggested by John for sparking the argument leading to his mother's death. It does appear that there had previously been encouragement for John to engage with statutory services, but he had never taken any steps to initiate contact.

61. With all the foregoing in mind the issues raised within the panel meetings and which should lead to further consideration for the future are as follows.

62. **Information sharing**

63. Information sharing is an essential element in the prevention and management of DV. There was a lack of inter-agency information sharing.

64. Within the police service there was information held on concerns held by John's sister about his strange behaviour in 2009. The panel considered that this information could have been developed by the police at the time to consider a community based response and passed information to appropriate health services.

65. When John was seen by CADAS July 2012 he was advised to see his GP concerning alcohol dependency. There was no process in place to formally follow this advice up with a letter to the GP.

66. There appears to be a lack of information sharing in place between CADAS and GP Primary care, however consideration needs to be given to confidentiality of clients visiting the CADAS service. Client's consent could be obtained to ensure effective communication with statutory health services.

67. Risk Assessment

68. When John came to police attention in 2009 an appropriate risk assessment was under taken in line with current policy at that time. However risk assessment should be considered as an on-going and dynamic process that can develop and gather further information essential for identifying and managing risk. In making the risk assessment statements of escalating behaviour need to be explored.

69. When John reported his high level of alcohol consumption to his GP he was appropriately assessed as being alcohol dependent. It is not apparent that this assessment would then be developed to consider the risk presented by an alcohol dependent person to their family and community.

70. **Understanding of the existence of DV**

71. No agency involved in this DHR process was aware of any DV being present between Sarah and John before the homicide.

72. John's partner had expressed concerns over the effect of his drinking on his relationship with her in a telephone conversation with CADAS, but she did not disclose that there was DV. Given the prevalence of DV and the associated risks then this should always be a consideration when clients wish to discuss relationships. There should always be a process that enables intimate partners to speak in private.

73. Agencies were not aware of the threat that John presented to his partner Debbie a few weeks before the incident. They were therefore not in a position to assess, respond, or refer any potential DV issues.

74. **Police action**

75. There are no concerns over the initial response to the death of Sarah. Cumbria Constabulary staff were provided with clear evidence and adopted appropriate investigation procedures taking immediate steps locate and arrest John, reducing the risk to the public.

76. **Mental Health**

77. The issue of mental health is common in many cases of DV, this has been considered. There were no recorded concerns on the mental health of Sarah during the timescales of the DHR review period. There had been no historic concerns recorded in relation to John's mental health. In 2009 John's sister raised concerns about her brother's strange behaviour. John was seen by his GP on three occasions after that date and there were no mental health issues recorded.

78. Whilst in police detention for his mother's murder, John was assessed by a police FME for his fitness to be detained and interviewed. John was initially too intoxicated for a full clinical interview. When he was later reviewed he was referred to the CIAT for a mental health assessment. The CIAT is a service provided by Cumbria Partnership Foundation Trust. There are no formal protocols between the trust and police for mental health assessments. This referral process could fall outside a DHR, but the panel felt it important to use this opportunity to improve police and mental health liaison.

79. The issue of mental health was raised at John's trial. The defence represented that John had a schizotypal personality disorder and alcohol dependency syndrome; this was countered by prosecution consultant forensic psychiatrist who stated that intoxication played a bigger part than any disorder. This supported the CIAT assessment made immediately after the homicide. The trial judge did not make any recommendation for treatment orders on conviction.

80. **Housing**

81. A full review has been undertaken by Cumbria's Impact Housing and there are no records held in relation to the parties subject to this report. It is appreciated that John was living in a caravan, within a barn at his mother's farm but there have been no requests for social housing from the family.

82. **Support Services**

83. Domestic violence support for this area is provided by Letgo Impact Housing. There are no records of contact from any parties subject of this report in Letgo case management or MARAC files. Letgo also provide DV training for GPs in the Cumbria region.

84. DHR process has not identified any declared financial strains on the parties involved. John was not in full time employment and his mother was retired. There is no record of either party seeking financial assistance through local benefits.

85. **Substance Misuse**

86. The issue of substance misuse is a recurring concern in this review and it was a key factor in the homicide and the criminal trial. John was found to be intoxicated on his arrest and suffering from the effects of withdrawal when CIAT examined him whilst in police detention.

87. In the years leading up to the homicide John had never been formally referred for treatment or taken up advice to self-refer to other agencies. He had been provided with advice on how to self refer to third-sector agencies since 2005. Even though there were statutory NHS providers for substance abuse problems, the formal referral was never made.

88. John was previously known to cultivate cannabis, but misuse of controlled drugs was never highlighted as concern by the family, health services, CADAS, or the police investigation into this homicide.

89. It is not known what effect any prescribed treatment could have had on the behaviour of John, it is apparent that the offer of self-referral did not work. Whilst it is appreciated that there is a level of personal responsibility to manage health, a more robust referral process between GP, NHS providers and third sector may have compelled John to take up the treatment and support offered.

90. **A culture of questioning**

91. There are a number of occasions when agencies came into contact with the family and the circumstances were such that questions should have been asked about the domestic environment. The incidents where John's behaviour and alcohol consumption came to the attention could have been examined to ascertain what effect this was having on his health and the safety of other family members.

92. It was apparent from the incident in June 2009 that John's alcohol consumption was affecting his family and they had concerns. In 2010 John informed his GP that he was seeking help as his mother had concerns. Then in July 2012 John's partner reported concerns on alcohol and her relationship.

93. It is appreciated that questioning on domestic relationships could be considered intrusive, however the need to ensure that safe and healthy relationships must be considered as a priority. There should be training to support a culture of questioning and establishing healthy relationships.

94. **Policies and processes**

95. It appears that existing policies and processes are in place within agencies to support the identification and prevention of DV. Police processes for risk assessment have changed since the reported incident in 2009 and there is no requirement to change these.

96. In relation to substance misuse the established referral pathway from GP to NHS services was not followed, relying on patients self-referring to third sector agencies.

97. This review has also identified that there are no formal referral pathways between police and CIAT for mental health assessments on detained persons.

98. **Family contact**

99. The guidance for DHRs recommends that families and friends should be a part of the DHR. The panel gave careful consideration on who would be the most appropriate person to involve. It was decided to approach Claire, the daughter of the victim. There were some initial delays in making contact with Claire and her details were passed directly to the chair of the DHR to initiate contact. The chair interviewed Claire and provided her with a copy of terms of reference and the home office leaflet for families.

100. Claire provided valuable information to the panel that was not revealed during the IMR process. Sarah was well known and respected within the community, supporting the brownies and as a trustee of the playgroup. Although there was regular community contact, Sarah kept her family relationships very private. Claire was very worried about her brother's behaviour but could not convince her mother to share her concerns. After Claire reported her brother's behaviour to police in 2009, Sarah was very upset with her daughter and was more supportive of her son. Sarah was determined to keep family matters private. Claire told her mother that now she had taken a stand against her brother by reporting him to the police, it was likely that Sarah would be the target of his aggression. She accepted her daughters view.

101. Sarah seemed determined to support her son through his alcohol dependency, but wanted to retain the family's privacy. It was revealed that, on the day before her death, Sarah had booked an appointment for John to attend a private residential alcohol rehabilitation centre in Lancashire. John was due to attend on 22 August 2012.

102. Claire did not believe that agencies could have predicted her mother's death or done anything effective to prevent it. She described her mother as very being very stoic and private on family matters and she would not have reported any incidents were her son.

103. **Equality and diversity**

104. The nine protected characteristics as defined by the Equality Act of 2010 have all been considered within this review. (They are: age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, sexual orientation.) The issue of mental health would be considered as disability and this had been addressed in the body of the report. The only other relevant characteristic is the age of the victim.

105. The victim was 77 years old at the time of her death. It appears from GP records that she was fit and healthy with only minor conditions being reported. Although she lived in an isolated area, she had no mobility issues and visited her GP and did not require district-nursing services at home. Sarah had her daughter living at the same property but no immediate neighbours. There is no suggestion that Sarah was subject to financial abuse due to her age.

106. In consideration of the victim's age the panel consulted with Age UK South Lakeland. It was considered, given the apparent general health and mobility of Sarah, that the number of visits to her GP could have been an indicator of underlying problems domestic problems. Sarah was known to the local agent of Age UK but was not known to them as a volunteer or a beneficiary of services. Age UK have taken steps, outside this review process, to engage with issues of DV. It has been agreed that a member of Age UK village agent teams would be involved in Multi-Agency Risk Assessment Conferences (MARAC) discussions, to enable better understanding of issues affecting this area including; geography, economy, local politics, looking at community strengths and what works.

107. One consideration mentioned throughout this report is the isolated geographical location of this family in the community. Cumbria is the second least densely populated county in England and this family lived in a farmhouse in that area. Any interaction with agencies mentioned within this report happened as a result of a member of the family visiting those services or requesting police attendance at the address. Whilst it is appreciated that DV is a crime that will often take place in

private, the remote location of this family would not bring them into contact with close neighbours able to report their concerns.

Conclusions

108. The issue of preventability

109. This case has allowed examination of current statutory systems and processes in relation to risk assessment, management and domestic violence. Although agencies have generally followed policies in relation to their internal working relationships, it has demonstrated that the dynamics of intimate relationships were not effectively explored.

110. One factor in this case has been the failure to refer John to appropriate NHS substance misuse providers. It is not believed that Sarah's death could have been prevented, but the lack of communication between agencies meant that the risks apparent now were not recognised and managed. Therefore better inter-agency processes may help prevent future tragedies.

111. The IMRs across statutory agencies highlight some failings but not of sufficient gravity to indicate that Sarah's death could have been avoided if the circumstances within the agencies had been different. However, if information was shared, in line with established policy, then the heightened risk presented by John could have been addressed. Standard processes may also not have been enough in this case. Consideration needs to be given to how information is passed between third-sector agencies and statutory agencies, whilst considering the confidentiality of clients.

112. For these reasons it is important to test the performance of the agencies working individually and together to satisfy the partnership that things have improved. The recommendations are designed to achieve this outcome and fall largely into the following areas:

- Partnership effectiveness
- Policies and processes (including referral/care pathways)
- Perpetrators
- Training – dynamics and practice
- National outcomes

113. Whilst information about John is limited prior to his arrest in August 2012 it is he who went on to kill Sarah. It is clear that agencies must consider the affect of substance misuse on the perpetrator and families in DV cases with a view to understanding the dynamics and the possible indicators of abusive behaviour. The contribution of the victim's family has provided a valuable insight. It appears that the referral of John to a private rehab centre immediately before her death could have heightened tensions within the home. This emphasises the need to safeguard effective partnerships across statutory services, third sector agencies; engaging with families to identify and respond to risks.

114. This case has highlighted the fact that DV is present in all communities, urban and rural, and that consideration be given to the needs families in more isolated communities. John had a long-standing alcohol dependency and he had made threats of violence towards his partner. This case does not reveal a failure to deal with long standing reported issues of DV, it highlights the need to maintain a dynamic view of potential risks to all members of a family and in particular those vulnerable

through age. The scale and threat of DV is known to all statutory agencies and they have processes in place to address the obvious risks. If agencies consider the dynamics of personal relationships and the increased risk of DV when there is substance misuse, then future cases could be managed to a more positive conclusion.

115. Recommendations

116. The recommendations below are, in the main, for the partnership as a whole but many organisations have internal recommendations that mirror these. It is suggested that the single agency action plans should be subject of review via the action plan hence the first recommendation.

1) That all agencies report progress on their internal action plans to the relevant task and finish group of South Lakeland CSP.
2) That the partnership conducts a review of its effectiveness to establish its strengths and weaknesses. This review, which should be completed by a task and finish sub-group of the South Lakeland CSP, to include an examination of:
    - The risk assessment processes across all agencies coming into contact with victims and perpetrators of DV;
    - The effectiveness of information sharing;
    - The existence and application of agency polices and procedure in relation to DV;
    - The effectiveness of support to persons living in isolated communities;
    - The effectiveness of partnerships in managing substance misuse; and
    - The effectiveness of raising DV awareness and third party reporting schemes in county wide and with special consideration of remote communities.
    - The effectiveness of public awareness raising.
3) That training strategy be reviewed, to ensure the following:
    - To allow frontline practitioners to understand the dynamics of DV and good practice;
    - To support an increase in questioning about DV and potential risk; and
    - To support an increase in questioning around substance misuse and healthy relationships.
4) That NHS Primary Care examine its processes for referring persons with substance misuse problems to statutory NHS services (including risk assessment), to include consideration of the method of making plans of combining this with referrals to community based third sector agencies.
5) That Cumbria Constabulary and Cumbria Partnership Foundation Trust (CPFT) embed referral pathways and protocols for mental health assessments for detained persons.
6) That the Home Office be asked to consider amending DHR guidance to include the impact of substance misuse on inter-familial relationship

Glossary of terms	
AA	Alcoholics Anonymous
Sarah	Victim
AC	Victim's daughter
AD	Perpetrator's partner
ASC	Adult Social Care
AUDIT	Alcohol Use Disorders Identification Test
John	Victim's son - perpetrator
CADAS	Cumbria Alcohol and Drugs Advisory Service
CC	Cumbria Constabulary
CCC	Cumbria Constabulary County Council
CIAT	Crisis Intervention Assessment Team
CPFT	Cumbria Partnership NHS Foundation Trust
CPS	Crown Prosecution Service
CS	Children's Services (Children's Social Services)
CSP	Community Safety Partnership
DHR	Domestic Homicide Review
DV	Domestic violence
FLO	Family Liaison Officer
FME	Forensic Medical Examiner
GP	General Practitioner
IMR	Individual Management Review
MARAC	Multi-Agency Risk Assessment Conferences
NHS	National Health Service
UHMBT	University Hospitals of Morecambe Bay NHS Foundation Trust
Unity	Unity Greater Manchester West Mental Health Trust

Appendix 1

Domestic Homicide Review Terms of Reference for Sarah

This Domestic Homicide Review is being completed to consider agency involvement with Sarah, and her son, John, following her murder on 21st August 2012. The Domestic Homicide Review is being conducted in accordance with Section 9(3) of the Domestic Violence Crime and Victims Act 2004.

The Review will work to the following Terms of Reference:

1) Domestic Homicide Reviews (DHR) place a statutory responsibility on organisations to share information. Information shared for the purpose of the DHR will remain confidential to the panel until the panel agree what information is shared in the final report when published.

2) To explore the potential learning from this murder and not to seek to apportion blame to individuals or agencies.

3) To review the involvement of each individual agency, statutory and non-statutory, with Sarah and John during the relevant period of time: 1 January 2009 – 21 August 2012**.**

4) To summarise agency involvement prior to 1 January 2009.

5) The contributing agencies to be as follows:
   a) Age UK South Lakeland
   b) Cumbria Alcohol and Drug Advisory Service (CADAS) (IMR and chronology)
   c) Cumbria Police (IMR and chronology)
   d) Cumbria PCT
   e) Cumbria County Council – Children's Services
   f) Cumbria County Council - Adult Social care (summary)
   g) Cumbria NHS Partnership Trust (IMR and chronology)
   h) Crown Prosecution Service
   i) GP Services – Primary Care (IMR and chronology)
   j) Impact Housing / Let Go (summary)
   k) South Lakeland District Council (summary)
   l) UHMBT (IMR and chronology)
   m) UNITY (IMR and chronology)

6) For each contributing agency to provide a chronology of their involvement with Sarah and John during the relevant time period.

7) For each contributing agency to search all their records outside the identified time periods to ensure no relevant information was omitted, and secure all relevant records.

8)
   a) For each contributing agency to provide an Individual Management Review: identifying the facts of their involvement with Sarah and/or John critically analysing the service they provided in line with the specific terms of reference; identifying any recommendations for practice or policy in relation to their agency.

b) To consider issues of activity in other areas and review impact in this specific case.

9) In order to critically analyse the incident and the agencies' responses to the family, this review should specifically consider the following five points:
    1. Analyse the communication, procedures and discussions, which took place between agencies.
    2. Analyse the co-operation between different agencies involved with the victim, alleged perpetrator, and wider family.
    3. Analyse the opportunity for agencies to identify and assess domestic abuse risk.
    4. Analyse agency responses to any identification of domestic abuse issues.
    5. Analyse organisations access to specialist domestic abuse agencies.
    6. Analyse the training available to the agencies involved on domestic abuse issues.

    And therefore:
    i) To establish whether there are lessons to be learned from the case about the way in which local professionals and agencies work together to identify and respond to disclosures of domestic abuse.
    ii) To identify clearly what those lessons are, how they will be acted upon and what is expected to change as a result and as a consequence.
    iii) To improve inter-agency working and better safeguard adults experiencing domestic abuse.

10) Agencies that have had no contact should attempt to develop an understanding of why this is the case and how procedures could be changed within the partnership, which could have brought Sarah or John in contact with their agency.

11) To sensitively involve the family of Sarah in the review, if it is appropriate to do so in the context of on-going criminal proceedings. Also to explore the possibility of contact with any of the alleged perpetrator's family who may be able to add value to this process.

12) To coordinate with any other review process concerned with the child/ren of the victim and/or perpetrator.

13) To commission a suitably experienced and independent person to chair the Domestic Homicide Review Panel, co-ordinating the process, quality assuring the approach and challenging agencies where necessary; and to subsequently produce the Overview Report critically analysing the agency involvement in the context of the established terms of reference.

14) To establish a clear action plan for individual agency implementation as a consequence of any recommendations.

15) To establish a multi-agency action plan as a consequence of any issues arising out of the Overview Report.

16) To provide an executive summary.

17) To conduct the process as swiftly as possible, to comply with any disclosure requirements, and on completion, present the full report to the South Lakeland Community Safety Partnership.

Appendix 2

Panel members and agencies represented

Agency represented	Panel members
Crown Prosecution Service	Jonathan Storer
Cumbria Alcohol and Drugs Advisory Service (CADAS)	Natalia Wealleans-Turner
Cumbria Constabulary	Mike Forrester
Cumbria County Council Adult Social Care	Judith Whittam
Cumbria County Council Children's Services	Catherine Witt
Cumbria County Council Community Safety	Mark Clement
Cumbria Partnership NHS Foundation Trust (CPFT) – Mental Health Services	Alison Brown
Impact Housing and Let Go Domestic Violence Project	Jo Scarlett
NHS Cumbria Clinical Commissioning Group Primary Care	Venetia Young
South Lakeland Community Safety Partnership	Jenny Draper
South Lakeland District Council	Debbie Storr
Standing Together (Independent Chair)	Mark Yexley
Unity Greater Manchester West Mental Health Trust	Kate Hall Keith Murphy
University Hospitals of Morecambe Bay NHS Foundation Trust (UHMBT)	Mary Moore

Domestic Homicide Review (DHR) into the death of Sarah

Action Plan

The Panel is responsible for ensuring that all recommendations must be SMART (specific, measureable, achievable, realistic, time bound) and for the completion and implementation of the Action Plan.
The CSP will monitor the implementation and delivery of the Action Plan.

Recommendation	Action to take	Lead	Key milestones achieved in enacting recommendation	Target Date	Date of completion and outcome
Theme 1 – Local partnership – South Lakeland					
That all agencies report progress on their internal action plans to the relevant task and finish group of South Lakeland CSP.	Panel identified 2 agencies to produce internal action plans	Natalia Wealleans - Turner(CADAS) Venetia Young (GP services)	1. CADAS and GP services produce internal action plans 2. Progress report presented to South Lakeland CSP	December 2013 January 2014	CADAS completed plan submitted April 2014. GP services work in progress Report presented 31 January 2014
Theme 2 – Processes – Cumbria wide					
That the partnership conducts a review of its effectiveness to establish its strengths and weaknesses. This review, which should be completed by a task and finish sub-group of the South Lakeland CSP, to include an examination of:	Convene a county wide working group under Safer Cumbria to undertake this review and link to learning from second DHR in Cumbria	Louise Kelly (CCC DV Lead Officer) / Jenny Draper (South Lakeland CSP)	1. Safer Cumbria agree this approach 2. Working group convened and meeting dates scheduled 3. Interim progress report to SLCSP 4. Review completed with agreed actions 5.Actions applied by all agencies	October 2013 November 2013 January 2014 March 2014 July 2014	23 October 2013 First meeting held Feb 2014 Report presented 31 January 2014 Action plan being developed

Recommendation	Action to take	Lead	Key milestones achieved in enacting recommendation	Target Date	Date of completion and outcome
• The risk assessment processes across all agencies coming into contact with victims and perpetrators of DV; • The effectiveness of information sharing; • The existence and application of agency polices and procedure in relation to DV; • The effectiveness of support to persons living in isolated communities; • The effectiveness of partnerships in managing substance misuse, especially within inter-familial relationships; • The effectiveness of raising DV awareness and third party reporting schemes in county wide and with special consideration of remote			6. Final report to SLCSP and submission to Home Office	July 2014	Report submitted to Home office Dec 13. QA response received March 2014 – assessed as adequate

Recommendation	Action to take	Lead	Key milestones achieved in enacting recommendation	Target Date	Date of completion and outcome
communities; • The effectiveness of public awareness raising.					
That NHS Primary Care examine its processes for referring persons with substance misuse problems to statutory NHS services (including risk assessment), to include consideration of the method of making plans of combining this with referrals to community based third sector agencies.	Develop a model of interagency good practice to ensure patient / client referrals to and responses from all involved agencies are formally logged and followed up. (This will exclude reliance on self referrals)	Natalia Wealleans - Turner(CADAS) Venetia Young (GP services Claire Sinclair (Unity)	1. Utilise CADAS and GP Service action plans as a basis for the model 2. Agree a model of practice and share with all partners 3. Nominated person per agency to monitor compliance 4. Interim report to SLCSP 5. Final report to SLCSP and Home Office	November 2014 January 2014 January 2014 January 2014 July 2014	
Theme 3 – Perpetrators – Cumbria wide					
That Cumbria Constabulary and Cumbria Partnership NHS Foundation Trust (CPFT) embed referral pathways and protocols for mental health assessments for detained persons.	Share existing Protocol with all relevant staff and officers	Supt Mike Forrester (Cumbria Police) Alison Brown (CPFT)	1. Copy of protocol available to all relevant staff 2. Protocol established within working practice for all key staff e.g. SIOs and Forensic Nurses 3. Report to SLCSP	October 2013 November 2013 January 2014	Action completed and protocol in use

Recommendation	Action to take	Lead	Key milestones achieved in enacting recommendation	Target Date	Date of completion and outcome
Theme 4 – Training – Cumbria wide					
That training strategy be reviewed, to ensure the following the review: • To allow frontline practitioners to understand the dynamics of DV and good practice; • To support an increase in questioning about DV and potential risk; and • To support an increase in questioning around substance misuse and healthy relationships.	Convene a county wide working group under Safer Cumbria to undertake this review and link to learning from second DHR. Develop a sustainable and shared agency approach to DV training and build a pool of DV trainers	Louise Kelly (CCC DV Lead Officer) / Jenny Draper (South Lakeland CSP)	1. Safer Cumbria agree this approach 2. Working group convened and meeting dates scheduled 3. Interim progress report to SLCSP 4. Review completed with agreed actions 5. Actions applied by all agencies 6. Final report back to South Lakeland CSP and Home Office 7. Produce a case study to share	October 2013 November 2013 January 2014 March 2014 July 2014 July 2014 July 2014	23 October 2013 First meeting held Feb 2014 Report presented 31 January 2014 Action plan developed Report submitted to Home office Dec 13. QA response received March 2014 – assessed as adequate
Theme 5 – National outcomes					
That the Home Office be asked to consider amending DHR guidance to include the impact of substance misuse on inter- familial relationships	Include a recommendation in the final report to South Lakeland CSP and submission to the HO	Graham Vincent SLCSP Chair	1. Report submitted to Home Office	July 2014	Completed The Panel advised in their letter that the DHR lessons learned document already contained guidance on complex needs

Home Office

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LA9 4DQ

XX March 2014

Dear Ms Draper,

Thank you for submitting the Domestic Homicide Review (DHR) report from South Lakeland Community Safety Partnership to the Home Office Quality Assurance (QA) Panel. The review was considered at the QA Panel meeting in February.

The QA Panel would like to thank you for conducting this review and for providing them with the final report. In terms of the assessment of DHR reports the QA Panel judges them as either adequate or inadequate. It is clear that a lot of effort has gone into producing this report, and I am pleased to tell you that it has been judged as adequate by the QA Panel.

There were some issues that the Panel felt might benefit from more detail and which you may wish to consider before you publish the final report:

- The report submitted says that "The Chair has made an approach to interview the perpetrator in prison and is currently awaiting a response". This could be interpreted as the report being submitted before completion. However, the interview material was submitted later and separately to the report. Unfortunately it was not sent in time to reach the QA Panel and was not considered by them. Please amend the report before publication to reflect this new information and incorporate the Chair's analysis of it within the body of report itself;

- Please include some text to clarify the delays in the timescales for submitting the report;

- Please include some text to clarify who the voluntary sector and/ or domestic violence specialists were on the DHR Panel;

- Many of the completion dates in the action plan have now passed and whilst some are marked as completed, the others should be updated to show the current position and progress made. Including a RAG rating may assist with monitoring progress; and,

- Please produce an Executive Summary, summarising the key points and lessons from this report. Please remember that the Executive Summary, the Overview Report, and Action Plan are all anonymised, and all identifiable references are removed before submission in order to protect identities and comply with the Data Protection Act 1998, in accordance with paragraph 9.2 of the Statutory Guidance for the Conduct of Domestic Homicide Reviews.

The QA Panel also noted that the review makes a national recommendation for the Home Office to revise the DHR Statutory Guidance to include information on the impact of substance misuse on inter-familial relationships. The QA Panel considers that the DHR Guidance is not an appropriate document in which to incorporate advice on the impact of substance abuse on inter-familial relationships. The Home Office Domestic Homicide Reviews Lessons Learned document already contains helpful guidance on complex needs (including alcohol and substance abuse). It can be found at:
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/259547/Domestic_homicide_review_-_lessons_learned.pdf

The QA Panel felt it would be helpful if pseudonyms were used to describe those involved in this case, which would assist the reader in following the narrative.

We do not need to see another version of the report, but I would ask you to include this letter as an appendix to the report when published.

Yours sincerely,

Christian Papaleontiou, Acting Chair of the Home Office Quality Assurance Panel
Head of the Interpersonal Violence Team, Violent Crime Unit