OVERVIEW REPORT

DOMESTIC HOMICIDE REVIEW 5 - 2015

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INTRODUCTION

1.1 Domestic Homicide Reviews were introduced by the Domestic Violence, Crime and Victims Act (2004), section 9.

1.2 A duty on a relevant Community Safety Partnership to undertake Domestic Homicide Reviews was implemented by the Home Office through statutory guidance in April 2011. The 'Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews' was updated in August 2013 and that revision provided the framework within which this Review was conducted[1].

1.3 A Domestic Homicide Review (DHR) is defined[2] as:

A review of 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 person to whom he was related or with whom he was or had been in an intimate personal relationship, or
- a member of the same household as himself,

held with a view to identifying the lessons to be learnt from the death.

1.4 The purpose of a DHR 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 these lessons to service responses including changes to policies and procedures as appropriate; and
- Prevent domestic violence homicide and improve service responses for all domestic violence victims and their children through improved intra and inter-agency working.

1.5 DHRs are not inquiries into how the victim died or into who is culpable; that is a matter for Coroners and criminal courts. They are also not specifically part of any disciplinary enquiry or process; or part of the process for managing operational responses to the safeguarding or other needs of individuals. These are the responsibility of agencies working within existing policies and procedural frameworks.

[1] www.homeoffice.gov.uk.
[2] Domestic Violence, Crime and Victims Act (2004), section 9 (1).

2 Summary of Circumstances Leading to the Review

2.1 The perpetrator (R) is a son of the victim (S) and lived with him in Stoke-on-Trent.

2.2 In the early hours of a morning in March 2015 R reported to Staffordshire Police that he had attacked and seriously injured his father in his home. S was conveyed to the Royal Stoke Hospital[3] by ambulance and admitted to the High Dependency Unit.

2.3 R made further admissions to assaulting his father by punching and kicking him and was arrested. He was subsequently charged with an offence of wounding with intent and remanded in custody.

2.4 Seven days after the assault, in April 2015, S died in hospital of his injuries. R was subsequently charged with his murder.

2.5 On 11 May 2015 a Scoping Panel convened on behalf of the Stoke-on-Trent Responsible Authorities Group considered the circumstances of the case and concluded that the criteria for conducting a Domestic Homicide Review were met. A recommendation to commission a Domestic Homicide Review was endorsed by the Chair of the Responsible Authorities Group.

2.6 At Stafford Crown Court R pleaded guilty to the manslaughter of S but denied murder. Following a trial in November 2015 the jury was unable to reach a verdict on the murder charge. In June 2016, following further examination of the forensic evidence, the Crown Prosecution Service accepted R's plea of guilty to Manslaughter. He was sentenced to nine years imprisonment.

3 Terms of Reference

3.1 The full Terms of Reference for this Review are at Appendix A. The following is a summary of the key points.

3.2 The Review considered in detail the period from 1 June 2011 (in which month the Police attended a report of a fight between R and S) and the date in March 2015 when S received injuries from which he subsequently died. Summary information regarding significant events outside of this period was also considered.

3.3 The focus of the Review was on the following individuals:

Name	S	R
Relationship	Victim	Son of Victim
Gender	Male	Male
Age (April 2015)	55 years	34 years
Ethnicity	White British	White British
Address of S:	Stoke-on-Trent	

[3] Formerly the University Hospital of North Staffordshire.

3.4 In conjunction with the areas for consideration outlined at Section 4 of the Statutory Guidance the Review specifically considered the following issues:

- History of violence between the victim and alleged perpetrator
- Involvement of Adult Social Care in respect of the victim's support needs and the alleged perpetrator's role as a carer for the victim
- Involvement of alcohol dependency services with the victim and the lack of engagement by the victim with these.

4 Review Process

4.1 Requests to confirm the extent of their involvement with the subjects of this Review were sent to all statutory and voluntary agencies in Stoke-on-Trent and Staffordshire who may potentially have had such involvement. This scoping process was used as the basis for more targeted requests for Management Review Reports.

4.2 Management Review Reports were submitted by:

- North Staffordshire Combined Healthcare NHS Trust
- Shropshire Clinical Commissioning Group on behalf of NHS England (Primary Care Services)
- Staffordshire Police
- Stoke-on-Trent City Council
- University Hospitals of North Midlands NHS Trust.

4.3 R declined consent for the Review to access his primary health care records. The Shropshire Clinical Commissioning Group submission on behalf of NHS England was therefore unable to reflect any contact that R had with his GP that may have been relevant to the Review.

4.4 Other sources of information accessed to inform the Review included:

- An overview of domestic violence and abuse services in Stoke-on-Trent prepared by the City Council Personal Crime Programme Lead.
- Email correspondence with S's GP practice.

4.5 The Review Panel was chaired and this report of the Review was written by Chris Few, an Independent Consultant. Mr Few has chaired review panels and written overview reports on behalf of numerous Community Safety Partnerships, Local Safeguarding Children Boards and Local Authorities in connection with Domestic Homicide Reviews and Serious Case Reviews[4]. He has no professional connection with any of the agencies and professionals involved in the events considered by this Review.

4.6 The Review Panel comprised the following post holders:

- Lead Nurse Adult Safeguarding
  North Staffordshire and Stoke-on-Trent Clinical Commissioning Groups
  (On behalf of NHS England)

- Named Nurse for Safeguarding
  North Staffordshire Combined Healthcare NHS Trust

- Senior Investigating Officer

[4] Under the Children Act (2004) and its associated statutory guidance.

Staffordshire Police

- Manager
  Investigative Services Policy, Review and Development Unit
  Staffordshire Police

- Safer City Partnership Manager
  Stoke-on-Trent City Council

- Personal Crime Programme Lead
  Stoke-on-Trent City Council

- Adult Safeguarding Team Manager
  Stoke-on-Trent City Council

- Senior Nurse Safeguarding
  University Hospitals of North Midlands NHS Trust.

4.7 In addition to the scoping meeting on 11 May 2015, at which the factual background was shared, the Review Panel met on 28 July 2015 to consider contributions to and emerging findings of the Review. Subsequent communication between Review Panel members and endorsement of this report for forwarding to the Chair of the Stoke-on-Trent Responsible Authorities Group were conducted electronically.

4.8 Completion of the Review was delayed until after conclusion of the associated criminal proceedings in order to secure the contributions of S's family.

4.9 On 26 September 2016 the report was presented to and endorsed by the Stoke-on-Trent Responsible Authorities Group.

5 Parallel Processes

5.1 The criminal investigation into the killing of S was conducted in parallel with this Review.

5.2 HM Coroner for Stoke-on-Trent and North Staffordshire opened and adjourned an inquest pending the outcome of the criminal trial. That inquest will not now be reconvened.

6 Family Engagement

6.1 Members of S's family were advised of the Review at its outset. Following conclusion of the criminal proceedings one of S's sons met with the Chair of the Review Panel on 8 September 2016. No other member of the family network engaged with the Review.

6.2 R was also informed of the Review at its outset. Following conclusion of the criminal proceedings he was again contacted via his Offender Supervisor and invited to meet with the Review Panel Chair. He agreed to do so and the meeting took place on 14 September 2016.

6.3 Information provided by and the perspectives of both members of S's family have informed and been included within this report. The Review Panel Chair is grateful for their contributions.

6.4 Two aspects of professional involvement with the family after the death of S were also commented on by the younger son of S. First, he spoke very highly of the support provided to the family by the Police Family Liaison Officer, stating “He was brilliant”.

6.5 Conversely, he expressed disappointment that it had taken seven months, from November 2015 to June 2016, for the CPS to decide that they would accept R’s plea of guilty to manslaughter and that a second trial would not therefore be required. He reported receiving a letter from the CPS explaining that this was due to delays in getting the relevant decision makers together, but stated that he did not think this was a reasonable explanation for leaving family members in limbo for that length of time.

THE FACTS

7 Family Background

7.1 **S**

7.2 S was born in 1959. He married in 1979 and the couple had three children, the oldest of whom is R.

7.3 The marriage broke down during the latter part of the 1980s and the couple divorced. The three children thereafter lived with their mother.

7.4 In the late 1980s S began a new relationship and eventually moved with that partner and her two children into the home which he occupied for the remainder of his life.

7.5 S's relationship ended in 1998 at which time his partner and her children moved out of the property. S however remained in close contact with his ex-partner's children until his death.

7.6 S's GP records indicate that in 1995 he underwent surgery after stabbing himself following an argument with his partner. The record states that he made a good physical recovery, was followed up by a referral to a psychiatrist and was treated with anti-depressant medication. No other record of this has been identified by the Review.

7.7 Members of S's family informed the Review that S became very upset when his ex-partner got engaged then married and that this coincided with him starting to drink heavily. In 2009 S self-referred to an alcohol misuse service although he had disengaged and been discharged by them after 4 appointments.

7.8 S continued to receive appropriate primary and secondary health care services in respect of his existing conditions, diabetes and cataracts to both eyes. The negative impact of S's drinking on his physical health was recognised by his GP and advice given on this but S did not engage with any service to address his alcohol misuse or its consequences prior to 2014.

7.9 S's family report that he left his employment with the NHS in 2010 as a result of his problem drinking.

7.10 S had no relevant criminal convictions or cautions.

7.11 **R**

7.12 In 1992 (when aged 12 years) R went to live with his father and the new extended family at the request of his mother, as she could not cope with his aggressive temper. During a subsequent argument with his father R alleged that he had been pushed down some stairs and child protection procedures were engaged. The allegation was not substantiated but R remained an open case to children's social care. By the age of 15 R was essentially sofa surfing around friends' houses and occasionally sleeping on the floor at his mother's house. From then (1995) onwards R had intermittent contact with CAMHS services and was provisionally diagnosed with conduct disorder and emotional problems. He did not however engage well with CAMHS services.

7.13 Statements obtained during the course of the homicide investigation refer to occasions when R had been aggressive toward his siblings and the children of S's then partner when he was a teenager.

7.14 Following the break-up of his father's second relationship R lived with him on a more permanent basis.

7.15 In 1999-2000 R was seen by adult mental health services but his engagement was very poor and this led to his eventual discharge. No full understanding of his difficulties was achieved as they would change at each appointment and R had difficulty giving a coherent picture of what was a current problem and what was historical.

7.16 R was suspected of showing early signs of psychosis, although there were doubts over the evidence as at the time he was using LSD and amphetamines which could have been responsible for the symptoms. Extant records do not indicate that any services were provided to R in respect of his drug use. The Review Panel were informed that this was unlikely because at the time such services were only equipped to address misuse of opiates and alcohol. Regardless of this there is no subsequent indication of R using illicit drugs.

7.17 R had one caution for causing criminal damage as a youth and between 2000 and 2004 he was dealt with for criminal damage, assault, public order offences and drink driving on 6 occasions, receiving various non-custodial sanctions up to a 12 month conditional discharge.

7.18 R also had contact with the Police on two further occasions. In 2002 Police Officers attended S's home address where R had been fighting with a work colleague. Both had sustained injuries but neither party wanted to make any complaint and no further action was taken.

7.19 In 2003 Police Officers attended S's address where R (then aged 23) had had a heated argument with his father. Neither was injured, or alleged that they had been assaulted, and again no further action was taken.

7.20 Between 2004 and 2011 R is believed to have been in regular employment and did not come to the attention of the Police. When interviewed by the Police following the assault on his father in March 2015 R referred to discord between S and himself during this period but stated that it never came to the attention of any professional. R reiterated this to the Review Panel Chair.

7.21 Both Adult Social Care and Police records suggest that S treated his ex-partner's daughters as if they were his own. The homicide investigation identified that this appeared to be a source of resentment by R, who believed that they were exerting an undue and negative influence on S. R confirmed to the Review Panel Chair that he did believe this and that the daughters of S's ex-partner were also receiving money from S that they were not entitled to.

8 Summary of Events

8.1 **Domestic incident involving R and S - June 2011.**

8.2 On the evening of 3 June 2011 Staffordshire Police received an emergency telephone call from R who reported that he and his father had been fighting and had assaulted one another.

8.3 The call taker noted that the conversation was difficult because R seemed to have been drinking. He was saying that he was covered in blood and that they had both used kitchen knives.

8.4 Following risk assessment by a senior officer a response was deployed in accordance with that assessment.

8.5 On the arrival of the Police Officers R was found outside the house next to the rear door whilst his father was upstairs. Neither was in possession of a knife.

8.6 Neither individual had sustained any injury or wished to support a prosecution. It was reported that R had picked up a kitchen knife but it was not brandished towards or used against his father.

8.7 R was taken from the house to his mother's address and no further action was taken.

8.8 No other agency was informed of this incident at the time.

8.9 **S alcohol related health problems – August 2014 to March 2015**

8.10 On 8 August 2014 S was referred by his GP to the Royal Stoke Hospital (University Hospitals of North Midlands NHS Trust) for investigation of suspected Ascities[5]. Over the following weeks S had a number of outpatient appointments at the hospital gastroenterology clinic. In addition to drainage of fluid from his abdomen and identification of liver cirrhosis a CT head scan was carried out because S appeared confused. General atrophy of S's brain, consistent with misuse of alcohol, was identified.

8.11 At this time S reported that he had been drinking ½ bottle of vodka per day for around 3-4 years, although he had cut back his drinking over the preceding few months.

8.12 There is no indication that S's GP discussed alcohol misuse with him or considered services that would assist to address this at this time.

8.13 On 24 September 2014 S was admitted to the Royal Stoke Hospital suffering from amnesia, confusion and disorientation.

8.14 Following S's admission to hospital an alcohol liaison Nurse saw him a total of eight times in a 4 week period. The first contact was on 25 September 2014 and S declined support but was provided with a leaflet on alcohol related liver disease. Unfortunately on subsequent visits S was unable to recall what had been discussed with him previously and was therefore unable to engage with the service.

8.15 The alcohol liaison Nurse suggested that S's poor memory be assessed and a neuropsychiatric assessment was arranged.

8.16 On 20 October 2014 a referral was made by the Royal Stoke Hospital to Stoke-on-Trent City Council Adult Social Care requesting an assessment of S's support needs once he was discharged.

8.17 On 24 October 2014 the neuropsychiatric assessment at the Royal Stoke Hospital concluded that S should be admitted to the Harplands Hospital (NSCHT) for assessment of his amnesia and he was transferred that day.

8.18 Assessments at the Harplands Hospital concluded that S's memory problem was predominantly a psychological issue. They found that his memory was patchy and inconsistent, and that it improved over time. While there were some structural brain changes due to sustained alcohol misuse it was not felt that this was to the degree that would cause

[5] Ascites is when fluid fills the space between the lining of the abdomen and the organs. It usually occurs when the liver stops working properly

the reported difficulties. S was encouraged to spend increasing amounts of time at home, through short home visits, although he remained an inpatient of the hospital.

8.19 There is no record of any explicit consideration of S's mental capacity[6] whilst he was at the Harplands Hospital or subsequently.

8.20 On 27 October 2014, consequent to receipt of notification that S had been transferred to the Harplands Hospital the social care assessment of S requested by UHNM was discontinued and the case closed.

8.21 Whilst S was at the Harplands Hospital two of his children (including R) were regular visitors to the ward and frequently attended ward reviews of S's care. They reported feeling happy with his care on the ward.

8.22 A family history was taken from R and separately confirmed by his sibling and S's ex-partner. There is no record of any concerns being raised about family members' relationships with S. However reference was made to relationship difficulties between S and his son in the subsequent discharge letter from the Harplands Hospital. The basis for this has not been established; there is no prior reference to this in S's hospital notes and the member of staff who wrote this is not able to assist in this regard. The Review Panel concluded that this was likely to have been lifted from records made when R was a teenager.

8.23 An assessment to establish S's needs following discharge was carried out by the Harplands Hospital Outreach Team and it was identified that an occupational therapy and support package was required; to include a white board and timetable at home, support with preparing meals and that further assessment of his needs should be undertaken following discharge.

8.24 R was identified by S as his main carer and R was given information on support for carers in the local area. R was offered a Carer's Assessment but declined this and stated that he did not wish to be formally recognised as S's carer.

8.25 On 31 December 2014 S became physically unwell with gastro-intestinal bleeding due to varices[7], to the point that the Harplands Hospital could no longer manage his care. He was transferred to the Royal Stoke Hospital by ambulance and admitted.

8.26 On 8 January 2015 Harplands Hospital staff took the decision that as S had been having time at home and was in the late stages of discharge planning it was appropriate for him to be discharged home directly from the Royal Stoke Hospital when he was medically fit.

8.27 When informed of this Royal Stoke Hospital staff consulted with S and his family in order to plan his safe discharge home. Due to concerns regarding S's memory problems and that R would not be at home for long periods a re-referral was made on 12 January 2015 to Stoke-on-Trent City Council Adult Social Care for an assessment of S's future care needs.

8.28 The Adult Social Care assessment, conducted by a Social Worker based at the hospital, identified that one of S's ex-partner's daughters would be providing him with meals to ensure he received a diabetic diet and ate regularly. It was also documented that S's son managed his money for him although there was no other reference to this throughout the document and it did not specify which son[8]. In addition to the Occupational Therapy input arranged by the Harplands Hospital Outreach Team a domiciliary care package consisting of two 15-

[6] Mental capacity - to make decisions about care and treatment
[7] Varices are dilated blood vessels in the esophagus or stomach
[8] The Review Panel Chair was informed by R and S's younger son who contributed to the Review that this was R.

minute calls each day was identified as necessary to ensure that S remembered to take his medication. This was intended as a failsafe measure in support of prompts by telephone also being made by the daughter of S's ex-partner.

8.29 S was discharged from the Royal Stoke Hospital on 20 January 2015. Discharge information from the hospital was sent electronically to the GP in line with normal practice[9].

8.30 That day (20 January 2015) a NSCHT Occupational Therapist and a support worker saw S at home. They were aware that the domiciliary care package had also been arranged. Further visits were made on 10 February (after two abortive appointments – for one of which S was not at home and with the second cancelled due to bad weather), 26 February and 5 March 2015.

8.31 During these visits S sometimes reported feeling too unwell to continue with either assessment or activity and at one point put any further work on hold for a few weeks. There were two subsequent attempts to contact S by telephone but no further contact was established before his admission to hospital following the assault in March 2015.

8.32 Neither the Occupational Therapist nor the support worker received any indication from S that there was any violence between R and himself or that he felt at risk.

8.33 In conversation with the Review Panel Chair it was apparent that R believed that the Occupational Therapist and support worker had been told by S's ex-partner and her daughter that no support for S was required and that the professional had acceded to this and provided no services. It is clear that R's position on this is mistaken and unfounded.

8.34 Stoke-on-Trent City Council Adult Social Care received notification of S's discharge on 21 January 2015 and the domiciliary care visits commenced the following day.

8.35 On 23 January 2015 a Stoke-on-Trent City Council Social Worker made a post discharge telephone call to S's home. The Social Worker spoke with R who stated that thus far his father had been alright at home and the family would support him in overcoming any anxiety he may have with regard to coping there. There was also a discussion regarding the cost of the domiciliary care and S's ability to pay for this. It was agreed that S's case would be referred for review of his financial situation.

8.36 After this call, and arranging the agreed review, the Adult Social Care case was closed by the Social Worker.

8.37 On 23 January 2015 S was seen at his GP surgery and his misuse of alcohol discussed. He was advised to self-refer to Aquarius, a specialist alcohol treatment service, but did not do so.

8.38 On 24 February 2015 S had an outpatient review by a NSCHT Neuropsychiatrist. S reported that his memory and attention problems were improving and that the Occupational Therapist input was helpful. Following this appointment S's GP was advised that neuroimaging showed changes in keeping with alcohol misuse but had not confirmed the presence of dementia.

8.39 On 4 March 2015 the domiciliary care provider reported to Stoke-on-Trent City Council Adult Social Care that S let them into his property but when they got in he had seen to his own care needs and medication and they did not carry out any tasks. Adult Social Care contacted S to discuss the care provider's report. He agreed that he did not need the service and the domiciliary care package was cancelled.

[9] This process allows follow up by the GP within 3 days of discharge and supports continuity of care and treatment

8.40 The domiciliary care workers who had been attending S at home were not aware of any alcohol misuse or any concerns or issues relating to alcohol consumption. Similarly, the Occupational Therapist who visited S did not see any evidence that S was drinking alcohol and R confirmed to the Review Panel Chair that S was abstinent after his discharge from hospital.. There was however no formal monitoring or assessment by any agency or professional of whether this was the case.

8.41 **Assault and subsequent death of S**

8.42 In the small hours of a morning in March 2015 Staffordshire Police received a telephone call from R asking for the Police and ambulance to attend his home address. He stated; "I have come home drunk and repeatedly beaten my dad who is in a bad way."

8.43 Police Officers attended and as a result of further admissions made by R he was arrested for assaulting his father.

8.44 S was found upstairs in bed. He was semi-conscious and provided with medical attention by West Midland Ambulance Service paramedics prior to being taken to the Royal Stoke Hospital.

8.45 S was assessed in the Emergency Department and found to have serious head injuries, with his condition described as potentially life threatening.

8.46 Later that day detective officers interviewed R. R said that his father had problems in the past with alcohol and had some issues of dementia relating to his alcohol abuse.

8.47 R explained that they had argued regularly in the past and during some of those arguments the two had exchanged punches. However, the last occasion was in 2011 and since that incident their relationship had improved.

8.48 R said his father had been in a relationship with a woman who had two children who were about the same age as him. He did not like them and felt that they used his father, doing nothing to help his alcohol issues. He was of the opinion that they made things worse.

8.49 R said that he had finished work the previous day and then gone drinking. When he arrived home he was told by his father that he was going to look after a dog for one of his ex partner's children. R described that at this he exploded in temper and punched and kicked his father several times, during which his father made no attempt to fight back and only put his arms up to protect his face.

8.50 R said he then left the house for about half an hour and went for a walk in order to calm down. When he returned home he found his father upstairs in bed, bleeding from the mouth and with his eye starting to swell and close. He then telephoned the emergency services.

8.51 Following a review of the evidence by the Crown Prosecution Service R was charged with an offence of wounding with intent.

8.52 Consequent to the assault West Midlands Ambulance Service made a Safeguarding Vulnerable Adults referral to Stoke-on-Trent City Council in accordance with the Staffordshire and Stoke-on-Trent Inter-Agency Adult Protection Procedures. These procedures were discontinued following the death of S.

8.53 In April 2015 S died in the Royal Stoke Hospital, seven days after he was assaulted. Following consultation with the Crown Prosecution Service, Staffordshire Police charged R with the murder of S.

8.54 A post mortem examination of S identified the cause of death as multi-focal axonal injury and multiple brain haemorrhages, exacerbated by S's liver cirrhosis.

ANALYSIS

9 History of violence between S and R

9.1 It is clear from the information gathered during this Review that the relationship between S and R had at times been fractious and this extended back over many years. Misuse of alcohol by both R and S was a factor in some of the disputes and the positive relationship that S had with his ex partner's children also gave rise to tensions according to R. Very little of this however came to the notice of agencies and it was not until the investigation following S's death that a more complete account of their relationship was ascertained.

9.2 The Review identified two incidents involving R and S that were known to agencies prior to the period under review. In 1992 an allegation that R had been pushed down the stairs by S was investigated through child protection processes but was not substantiated. In 2003 the police attended a report of a heated argument between R and S. It was reported that neither had been injured or alleged any assault and no further action was taken.

9.3 In 2011 R reported to the Police that he and S had been fighting and assaulted each other. The police attended and established that neither individual had sustained an injury or wished to make a complaint. R was taken from the scene to his mother's address and no further action was taken. Policies and procedures in place at the time for dealing with such incidents were complied with.

9.4 Since 2011 significant changes to the domestic violence policies and procedures of Staffordshire Police have been made. Completion of DIAL[10] risk assessment is now mandatory for all domestic incidents regardless of either party's support for a police investigation. Compliance with these arrangements is subject to enhanced supervisory oversight and the arrangements provide a more robust accountability framework.

9.5 The revised policies and procedures would have required a different approach to the 2011 incident in terms of recording and risk assessment. The Review Panel concluded however that in the presenting circumstances this would not have led to any different follow up to that incident, and in particular would not have led to the engagement of Multi-Agency Risk Assessment Conference (MARAC) arrangements or domestic abuse support services.

9.6 The incident in 2011 is the only occasion during the period under review that professionals knew of any form of conflict, let alone violence, between R and S. This accords with R's position, maintained to the Police investigating S's death, that the relationship with his father had been better since 2011.

9.7 The only other reference to any issues in the relationship between R and S during the review period was in the discharge letter prepared by Harplands Hospital in January 2015, which was also reflected in the Adult Social Care Assessment. The basis of that statement has not been established and the Review Panel concluded that this was likely to have been lifted from records made when R was a teenager.

9.8 No other incidents of violence between R and S were reported to any agency during the period under review and there is no indication that agencies should have been aware of any such incident.

[10] A Domestic Incident Arrest Log (DIAL) form is used within Staffordshire Police to assess the level of risk within domestic abuse cases. The national definition of domestic abuse used by Staffordshire Police encompasses violence between family members as well as current and former intimate partners.

10 Involvement of Adult Social Care in respect of S's support needs and R's role as a carer for S

10.1 During the period under review and before his hospital admission in September 2014 it is clear that S's health was worsening, reflected in increasing contact with his GP. The nature of S's use of alcohol and medical conditions would have indicated a patient with care and support needs. The exact nature of these needs would be influenced to some extent, by his use of alcohol, which did vary.

10.2 Whilst S was an in-patient at both hospitals there was good engagement by staff with his carers and the Review identified this, as well as the organisation of Occupational Therapy support for when S was discharged from the Royal Stoke Hospital, as good practice.

10.3 Both members of S's family who contributed to the Review also had a positive view of the discharge support provided. Their view however diverged on the way that professionals engaged with family members, with S's younger son seeing this as good practice while R's perspective is that staff should only have discussed S with him, as next of kin. He particularly commented on any professional engagement with S's ex-partner and her daughters as being improper. This latter position does not appear to accord with the ongoing relationship that S had with the daughters of his ex-partner and the role that one of them played in the support arrangements for S.

10.4 Stoke-on-Trent Adult Social Care subsequently completed an assessment of S in early 2015 following a referral from the Royal Stoke Hospital whilst S was an in-patient there.

10.5 This was the second referral for assessment, an earlier assessment having been discontinued on the basis that S had been transferred to the Harplands Hospital. At that point it would have been appropriate for Adult Social Care to liaise with Harplands Hospital to consider whether the assessment should still be completed and to discuss the likely timescales for S to be discharged.

10.6 The Adult Social Care report to this Review identified that there were deficiencies in their assessment process and its recording on Care First[11] and that practice was not compliant with the agency's standards.

10.7 The details of contacts, discussions and meetings between the Social Worker and S were not recorded as they should have been.

10.8 Similarly, the phone contacts that the Social Worker had with R and other family members were not recorded. Further, it would have been appropriate for the Social Worker to meet family members in person and this did not happen.

10.9 The assessment should have included information on and explored S's mental capacity which was apparently, at least whilst he was in hospital, impaired. This should also have included why it was necessary for a family member to manage his finances and the arrangements for this. In this respect the Review Panel considered whether there might be any abuse of this by R but found no evidence that this was anything more than an expedient arrangement put in place because S needed assistance and R was living with him.

10.10 The 'carers' section within the assessment was not completed and no carer was identified. The provision of support by S's son and his ex partner's daughter should have been

[11] Care First is the Adult Social Care electronic recording system

recorded and a Carer's Assessment offered. Although R had earlier declined to be assessed as a carer for S a further offer should have been made to him at this time as well as to S's ex-partner's daughter.

10.11 Had a Carer's Assessment been conducted the tools used in Stoke-on-Trent focus on the carer's support needs and addressing the impact of the role. The tools do not include consideration of the carer's suitability to undertake the role or any risks that they may pose. The Review Panel considered that Carer's Assessments should include an element of risk assessment and have made a recommendation in that regard.

10.12 The relationship between S and R was described in the social care assessment as "fraught", however this was not expanded upon or explored further. Enquiries have been made with the Social Worker completing the assessment to establish the basis for this term being used. The Social Worker was unable to provide this and as outlined at 12.7 above the Review Panel concluded that this was likely to have been lifted from records made when R was a teenager.

10.13 On the basis of the assessment a domiciliary care package was arranged for after S's discharge to ensure that S remembered to take his medication, in addition to the planned Occupational Therapy input from the Harplands Hospital Outreach Team.

10.14 The shortcomings with regard to the quality of the Adult Social Care assessment, recording of case notes and post discharge review have been addressed as a competency issue with the Social Worker concerned and the senior practitioner who signed off the assessment. The Review Panel was however assured and accepted that irrespective of the practice employed the assessment would not have led to a different conclusion being reached on what services should be provided for S, which were appropriate.

11 Involvement of alcohol dependency services with S and the lack of engagement by S with these

11.1 The Review explored in detail the misuse of alcohol by S and the services provided to him in order to tackle this issue.

11.2 In 2009 S self-referred to a specialist alcohol misuse service but disengaged after a short period of time. With this exception there is no indication that alcohol misuse by S was ever referred to or identified by any service prior to August 2014 when he was referred to the Royal Stoke Hospital by his GP.

11.3 Following admission to the Royal Stoke Hospital in September 2014 the alcohol liaison service at the hospital reviewed S appropriately and endeavoured to engage him. However, due to his cognitive problems this had very limited success. In January 2015, following S's return to the Royal Stoke Hospital, the alcohol liaison service considered further engagement with him but was advised that his cognition had not improved to the point where this would be productive. Although S was not using alcohol by virtue of being in hospital, consideration of providing a service was appropriate as it may have increased the likelihood that S remained abstinent after his return home.

11.4 On S's discharge from the Royal Stoke Hospital in January 2015 there is reference in S's GP records of alcohol misuse being discussed with him and it was suggested that S self-refer to specialist alcohol misuse services. At this point S had been abstinent for four months due to his hospitalisation and although engagement of such services may have been appropriate if S needed support to remain abstinent it seems unlikely that he would self-refer at that stage.

11.5 There is no indication that S did resume his alcohol misuse or that he required any assistance in this regard. This was not however subject of any ongoing review by his GP or those professionals providing support to him. This and consideration of whether any associated support needs were being met would have been appropriate for a patient being treated for the consequences of their excessive alcohol consumption.

11.6 Liaison and communication between in-patient and primary care services was appropriate. Following S's discharge from hospital in January 2015 there was however no liaison between the NSCHT staff or those from the domiciliary care provider and the GP. This would have been beneficial to promoting a holistic perspective on S's health and support needs.

CONCLUSIONS

12.1 Whilst there are indications of violence within the relationship between R and S the seriousness and recency of these was not such that any agency or professional could reasonably be expected to have predicted the assault which led to S's death, or to have taken steps to prevent it.

12.2 The violent incident between R and S in 2011 was dealt with in line with the policies and procedures in place at the time. It is positive that subsequent improvements provide a more robust framework under which Staffordshire Police responds to domestic violence and abuse. Had these been in place in 2011 they would not however have led to any different follow up to the incident or the engagement of specialist domestic abuse services.

12.3 There were shortcomings with the quality and completeness of the Stoke-on-Trent Adult Social Care assessment of S and his circumstances in January 2015. However, the Review Panel concluded that better practice in this regard would not have led to a different conclusion being reached on what services should be provided for S, which were appropriate. Steps have already been taken by Adult Social Care to address the practice of the staff involved.

12.4 The Review Panel considered whether S should have been identified as a vulnerable adult at risk of harm[12], which may have led to a different response to his care arrangements. It was noted that, although he was recognised as someone with care and support needs in terms of his physical health and to a lesser degree his mental health, he had never been identified as being at risk of harm. The Review Panel found no reasonable basis for a different position to have been taken.

RECOMMENDATIONS

13.1 The Review Panel made the following recommendations:

1. *The Stoke-on-Trent Responsible Authorities Group should seek assurance that consideration of the suitability of carers and any risks posed by them is included in agencies' frameworks for the assessment of informal carers and hospital discharge planning arrangements.*

2. *The Stoke-on-Trent Clinical Commissioning Group should seek assurance that providers of health services for the medical consequences of alcohol abuse have in place pathways which encourage patients to access specialist services to address their future alcohol consumption.*

13.2 Recommendations for action to improve their services were also made by the agencies that contributed to this Review. These recommendations, along with the associated Action Plans are provided at Appendix B.

13.3 Implementation of action plans arising from recommendations of the Review Panel and the contributing agencies will be monitored under arrangements agreed by the Stoke-on-Trent Responsible Authorities Group. The Responsible Authorities Group will also implement a communications plan which ensures that learning from the Review is effectively disseminated.

[12] As defined by the Staffordshire and Stoke-on-Trent Adult Protection Procedures

Appendix A

DOMESTIC HOMICIDE REVIEW TERMS OF REFERENCE

1 Introduction

1.1 The Terms of Reference for this Domestic Homicide Review (DHR) have been drafted in accordance with the Staffordshire and Stoke Multi-agency Guidance for the Conduct of Domestic Homicide Reviews, hereafter referred to as "the Guidance".

1.2 The relevant Community Safety Partnership (CSP) must conduct a DHR when a death meets the following criterion under the Domestic Violence, Crime and Victims Act (2004) section 9, which states that a domestic homicide review is:
A review of 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 person to whom he was related or with whom he was or had been in an intimate personal relationship, or
- a member of the same household as himself,

held with a view to identifying the lessons to be learnt from the death.

1.3 An 'intimate personal relationship' includes relationships between adults who are or have been intimate partners or family members, regardless of gender or sexuality.

1.4 A member of the same household is defined in section 5(4) of the Domestic Violence, Crime and Victims Act [2004] as:

- a person is to be regarded as a "member" of a particular household, even if he does not live in that household, if he visits it so often and for such periods of time that it is reasonable to regard him as a member of it;
- where a victim (V) lived in different households at different times, "the same household as V" refers to the household in which V was living at the time of the act that caused V's death.

1.5 The purpose of undertaking a DHR 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** these lessons to service responses including changes to policies and procedures as appropriate; and
- **Prevent** domestic violence homicide and improve service responses for all domestic violence victims and their children through improved intra and inter-agency working.

2 Background:

2.1 In the early hours of a morning in March 2015 the alleged perpetrator reported to Staffordshire Police that his father had been attacked and seriously injured in his home. The victim was conveyed to the Royal Stoke Hospital by ambulance and admitted to the High Dependency Unit.

2.2 The alleged perpetrator, who admitted to assaulting his father by punching and kicking him, was arrested, charged with wounding with intent and remanded in custody.

2.3 Seven days after the assault on the victim he died in hospital of his injuries. The alleged perpetrator was subsequently charged with his murder.

3 Grounds for Commissioning a DHR:

3.1 A DHR Scoping Panel met on 11 May 2015 to consider the circumstances. The Panel agreed that the following criteria for commissioning a Domestic Homicide Review had been met:

CRITERIA:	
There is a death of a person aged 16 or over which has, or appears to have, resulted from violence, abuse or neglect.	**X**
The alleged perpetrator was related to the victim or was, or had been, in an intimate personal relationship with the victim.	**X**
The alleged perpetrator is a member of the same household as the victim	**X**

3.2 The recommendation to commission this Review was endorsed by the Chair of the Stoke-on-Trent Responsible Authorities Group.

4 Scope of the DHR

4.1 The Review should consider the period that commences from 1 June 2011 (when the Police attended a report of a fight between the victim and alleged perpetrator) to the date in March 2015 when the victim received injuries from which he subsequently died. The focus of the DHR should be maintained on the following subjects:

Name	S	R
Relationship	Victim	Alleged Perpetrator
Gender	Male	Male
Age (April 2015)	55	34
Ethnicity	White British	White British
Address of Victim:	Stoke-on-Trent	

4.2 A review of agency files should be completed (both paper and electronic records); and a detailed chronology of events that fall within the scope of the Domestic Homicide Review should be produced.

4.3 An Overview Report will be prepared in accordance with the Guidance.

5 Individual Management Reviews (IMR)

5.1 Key issues to be addressed within this Domestic Homicide Review are outlined below as agreed by the Scoping Panel. These issues should be considered in the context of the general areas for consideration listed at Appendix 10 of the Guidance.

- History of violence between the victim and alleged perpetrator
- Involvement of Adult Social Care in respect the victim's support needs and the alleged perpetrator's role as a carer for the victim
- Involvement of alcohol dependency services with the victim and the lack of engagement by the victim with these.

5.2 Individual Management Reviews are required from the following agencies:

- North Staffordshire Combined Healthcare NHS Trust
- Staffordshire Police
- Stoke-on-Trent City Council Adult Social Care
- Stoke-on-Trent Clinical Commissioning Group (on behalf of NHS England in respect of primary care services)
- University Hospitals of North Midlands NHS Trust.

5.3 IMR Authors should have no line management responsibility for either the service or the staff who had immediate contact with either the subjects of the DHR or their family members. IMRs should confirm the independence of the author, along with their experience and qualifications.

5.4 Where an agency has had involvement with the victim and alleged perpetrator a single Individual Management Report should be produced.

5.5 Background information and a summary of any significant and relevant events outside of the period considered by the review should be included in the IMR.

5.6 In the event an agency identifies another organisation that had involvement with either the victim or alleged perpetrator, during the scope of the Review; this should be notified immediately to Stoke-on-Trent City Council, to facilitate the prompt commissioning of an IMR / Summary Report.

5.7 Third Party information: Information held in relation to members of the victim's immediate family, should be disclosed where this is in the public interest, and record keepers should ensure that any information disclosed is both necessary and proportionate. All disclosures of information about third parties need to be considered on a case by case basis, and the reasoning for either disclosure or non-disclosure should be fully documented. This applies to all records of NHS commissioned care, whether provided under the NHS or in the independent or voluntary sector.

5.8 Staff Interviews: All staff who have had direct involvement with the subjects within the scope of this Review, should be interviewed for the purposes of the DHR. Interviews should not take place until the agency Commissioning Manager has received written consent from the Police Senior Investigating Officer. This is to prevent compromise of evidence for any criminal proceedings. Participating agencies are asked to provide the names of staff who should be interviewed to Stoke-on-Trent City Council, who will facilitate this process. Interviews with staff should be conducted in accordance with the Guidance.

5.9 Where staff are the subject of other parallel investigations (including disciplinary enquiries) consideration should be given as to how interviews with staff should be managed. This will

be agreed on a case by case basis with the Independent Review Panel Chair, supported by Stoke-on-Trent City Council.

5.10 Individual Management Review reports should be quality assured and authorised by the agency commissioning manager.

6 Parallel Investigations:

6.1 Where it is identified during the course of the Review that policies and procedures have not been complied with agencies should consider whether they should initiate an internal disciplinary processes. Should they do so this should be included in the agency's Individual Management Review.

6.2 The IMR report need only identify that consideration has been given to disciplinary issues and if identified have been acted upon accordingly. IMR reports should not include details which would breach the confidentiality of staff.

6.3 The Police Senior Investigating Officer (SIO) should attend all Review Panel meetings during the course of the Review.

6.4 The SIO will act in the capacity of a professional advisor to the Panel, and ensure effective liaison is maintained with both the Coroner and Crown Prosecution Service.

7 Independent Chair and Overview Report Author

7.1 The Review Panel will be chaired and the Overview Report prepared by Chris Few, an Independent Consultant. Mr Few has chaired review panels and written overview reports on behalf of numerous Community Safety Partnerships, Local Safeguarding Children Boards and Local Authorities in connection with Domestic Homicide Reviews and Serious Case Reviews. He has no personal or professional connection with any of the agencies and professionals involved in the events considered by this Review.

8 Domestic Homicide Review Panel

8.1 The Review Panel will comprise senior representatives of the following organisations:

- North Staffordshire Combined Healthcare NHS Trust
- Staffordshire Police
- Stoke-on-Trent City Council Adult Social Care
- Stoke-on-Trent Clinical Commissioning Group (on behalf of NHS England in respect of primary care services)
- University Hospitals of North Midlands NHS Trust

9 Communication

9.1 All communication between meetings will be in confirmed in writing and copied to Stoke-on-Trent City Council, to maintain a clear audit trail and accuracy of information shared. Email communication will utilise the secure portal established by Stoke-on-Trent City Council for that purpose.

10 Legal and/or Expert Advice

10.1 Stoke-on-Trent City Council, in consultation with the Independent Review Panel Chair, will identify suitable experts who would be able to assist the Panel in regard to any issues that may arise.

10.2 However, the Individual Management Review Authors should ensure appropriate research relevant to their agency and the circumstances of the case is included within their report.

10.3 The Overview Report will include relevant lessons learnt from research, including making reference to any relevant learning from any previous DHRs and Learning Reviews conducted locally and nationally.

11 Family Engagement

11.1 The Review Panel will keep under consideration arrangements for involving family and social network members in the review process in accordance with the Guidance. Any such engagement will be arranged in consultation with the Police Senior Investigating Officer and, where relevant, Family Liaison Officer.

11.2 The Independent Review Panel Chair will ensure that at the conclusion of the review the victim's family will be informed of the findings of the review. The Responsible Authorities Group will give consideration to the support needs of family members in connection with publication of the Overview Report.

12 Media Issues

12.1 Whilst the Review is ongoing the Staffordshire Police Media Department will coordinate all requests for information/comment from the media in respect to this case. Press enquiries to partner agencies should be referred to the Police Media Department.

13 Timescales

13.1 The review should be completed and submitted to the Chair of the Responsible Authorities Group by 11 November 2015.

Appendix B

Agency Recommendations

North Staffordshire Combined Healthcare NHS Trust

1. Staff to ensure that they assess service users' alcohol consumption using a recognised tool especially those that have a history of excessive alcohol use.

Stoke-on-Trent City Council – Adult Social Care

1. Assurance that all assessments of need are a comprehensive account of the service user's life/ history/ wishes/ feelings and aspirations.

2. All identified as supporting an individual by providing a caring role will be fully involved in the assessment process and their ability and willingness to fulfil that role will be determined and support to carry out that role will be provided where needed and deemed appropriate.

3. Domestic Violence awareness will remain part of the Adult Safeguarding Training/briefings.

4. All workers, including senior workers and Managers will be made aware of the findings of this report and areas of improvement.