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**NEWCASTLE DOMESTIC HOMICIDE REVIEW  
CONCLUDING REPORT INTO THE DEATH OF 'Mark'**

**Produced by Kath Albiston**

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## **PREFACE**

This Domestic Homicide Review (DHR) was carried out following the homicide of 'Mark' in March 2014. This was the fourth statutory homicide review carried out in Newcastle. It was carried out in accordance with Home Office guidance and section 9 (3) of the Domestic Violence Crime and Victims Act 2004.

We would like to express our profound sympathy to the family and friends of Mark.

We would also like to thank staff within all agencies that have contributed to this review, and express gratitude to the Safe Newcastle Partnership for their support with the process.

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## **1 INTRODUCTION**

### **1.1 Background to the Review**

1.1.1 In March 2014 Northumbria Police were called to the address of Mark, a man in his thirties, who was found with a serious stab wound, from which he later died. His partner, Ms K, was charged in relation to his death. Northumbria Police notified the Chair of Safe Newcastle Unit and it was confirmed that the case met the criteria for a Domestic Homicide Review under Section 9 of the Domestic Violence Crime and Victims Act. These criteria were that the death of a person over the age of 16 had occurred, and that the death appeared to be as a result of an act of violence from a person with whom he had been in an intimate personal relationship. The Safe Newcastle Unit subsequently notified the Home Office that a Domestic Homicide Review would be taking place.

### **1.2 Purpose of the Review**

1.2.1 The key purpose for undertaking Domestic Homicide Reviews is to enable lessons to be learned from homicides where a person is killed by a family member or someone with whom they are in an intimate relationship. In order for these lessons to be learned as widely and thoroughly as possible, professionals need to be able to understand fully what happened in each homicide, and most importantly, what needs to change in order to reduce the risk of such tragedies happening in the future.

1.2.2 DHRs are not inquiries into how the victim died or who is culpable; in the case of Mark this was a matter for the criminal courts to decide. As far as is possible, the review should be conducted in such a way that the process is seen as a learning exercise and not as a way of apportioning blame.

1.2.3 DHRs are not specifically part of any disciplinary enquiry or process. Where information emerges in the course of a DHR indicating that disciplinary action would be initiated, the established agency disciplinary procedures would be undertaken separate to the DHR process. Alternatively, some DHRs may be conducted concurrently, but separately to, disciplinary action.

1.2.4 The rationale for the review process is to ensure agencies are responding appropriately to victims of domestic abuse, by offering and putting in place appropriate support mechanisms, procedures, resources and interventions, with an aim to avoid future incidents of domestic homicide and violence.

1.2.5 The review will also assess whether agencies have sufficient and robust procedures and protocols in place, which are understood and adhered to by their staff.

**1.3 The Review Panel**

1.3.1 The Independent Chair and Overview Report Author, Kath Albiston, has had no involvement with Mark or Ms K or any of the professionals’ work being reviewed. She has been involved as author and/or Chair with a number of Domestic Homicide Reviews within the North East area, including previous reviews in Newcastle.

1.3.2 The review panel consisted of representatives of both statutory and non-statutory agencies. These were:

Kath Albiston	Independent Chair and Overview Report Author
Stephen Blades	Newcastle Gateshead Clinical Commissioning Group
John Douglas	Northumbria Police
Fiona Brown	Northumberland County Council Children’s Services
Linda Gray	Adult and Culture Services, Newcastle City Council
Val Murray	Newcastle upon Tyne Hospitals NHS Foundation Trust
Anne Marshall	Victim Support
Christine McManus	North East Ambulance Service NHS Foundation Trust
Janet Murphy	Escape Family Support
Anna Stabler	NHS England
Leesa Stephenson	Northumberland Tyne and Wear NHS Foundation Trust
Lesley Storey	Safe Newcastle
Robyn Thomas	Safe Newcastle
Joanne Wallace	Northumbria Community Rehabilitation Company
Peter Walton	National Probation Service – North East Region

1.3.3 Your Homes Newcastle attended the initial meetings but it was subsequently agreed that, as they had had no relevant contact with parties involved in the review, they would withdraw from the Panel. This decision was taken in consideration of the high number of ongoing DHR’s within the local area.

**1.4 The Review Process**

1.4.1 This report of a Domestic Homicide Review (DHR) examines agency responses and support given to Mark prior to the point of his death in March 2014.

1.4.2 The following key events took place in the undertaking of the review:

28/04/14	Initial Scoping Meeting – agencies’ chronologies requested.
18/06/14	Panel Meeting at which the terms of reference for the review were agreed and Panel membership finalised. This included identification of those agencies that were to undertake

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	Individual Management Reviews (IMRs). The date for submission of IMRs was agreed for 08/10/14. This extended period of three months was agreed due to workload demands of agencies in relation to both Domestic Homicide and Serious Case Reviews. In reaching such agreement it was also acknowledged that the review would be unable to be completed fully until the trial had concluded and that this was likely to take place in late 2014, early 2015.
31/07/14	Meeting between the Chair/Overview Author and Individual Management Review (IMR) authors.
11/09/14	Further IMR authors meeting to review first drafts of IMRs prior to Panel meeting.
15/10/14	Panel Meeting to review IMRs. It was agreed at this meeting that the overview report would not be completed until the criminal trial had concluded, due to further information needed.
20/03/15	Conclusion of criminal process. Ms K sentenced to 7 years imprisonment.
01/04/15	Discussion with Northumbria Police's Senior Investigating Officer.
09/04/15	Interview with Ms K.
14/05/15	Submission of IMR by National Probation Service.
18/05/15	First draft of overview report circulated to Panel members.
22/05/15	Panel meeting to review first draft of overview report.
30/06/15	Meeting with Ms K's previous employer.
30/09/15	Submission of IMR from Escape family support.
28/10/15	Panel meeting to review second draft of overview report.
27/11/15	Final Panel meeting and completion of Action Plan.

- 1.4.3 In order to ensure the review process was sufficiently thorough, Newcastle Children's Services were contacted to see if they had had any relevant contact or information. They had extremely limited involvement consisting solely of the sending of two letters in 2007, prior to the review period, this is considered where relevant within this report.
- 1.4.4 Contact was also made with a number of other agencies to ascertain if they had any information relevant to the review. In response to this, Women's Aid and Positive Response to Overcoming Problems of Substance Misuse (PROPS) both confirmed that they had had no contact with either the victim or the perpetrator in this case. The North East Council on Addictions (NECA) reported having had no contact with Ms K, and just one brief contact with the Mark dating back to 2006, which was not felt to contain any information relevant to the review.
- 1.4.5 During the review process it also came to light that Ms K had had contact with Escape Family Support, a drug and alcohol service in the Northumberland area. Such contact was prior to the review period however due to its relevance ESCAPE agreed to complete an IMR.

- 1.4.6 Whilst the National Probation Service (NPS), North East Region, were identified as holding Ms K's records following the split of the Northumbria Probation Trust into two organisations, it was felt that the learning identified within their IMR was also relevant for Northumbria Community Rehabilitation Company (CRC). As a result the CRC were provided with details of the IMR completed by NPS and invited to comment on how they may wish to implement recommendations within their own organisation (Appendix 1). In addition general recommendations arising from the review in relation to the Probation Service were agreed by both the National Probation Service and Northumbria Community Rehabilitation Company.
- 1.4.7 In addition to the above, an interview took place with one of Ms K's previous manager's to provide further background and context for the review.
- 1.4.8 Discussion also took place within the Panel regarding the need for expert opinion in relation to the fact that this review related to a male victim of domestic homicide. As no local agencies were known that deal solely in supporting male victims of domestic abuse, Victim Support were identified as the most relevant agency to provide this perspective, in that they offer support to both male and female victims of domestic abuse. As such it was agreed they would be asked to specifically consider the review process from the perspective of male victims and advise the review Panel accordingly throughout. In preparing this report consideration was also given to a previous review that took place within the Newcastle area, in which the victim was also male, to identify any similar or recurring issues.
- 1.4.9 The total review process took longer than the Home Office guidance around timescales for a number of reasons. Firstly, due to a number of ongoing DHRs and Serious Case Review in the local area, an extended time period was granted for the completion of IMRs at the beginning of the process. Secondly, the first draft of the overview report could not be completed until full information from the criminal proceedings could be disclosed, and discussion could take place with the Senior Investigating Officer and the perpetrator. Finally, the first draft of the overview report raised further questions and it was agreed that some amendments were needed to existing IMRs, and that further corroborative information should be sought, details of which have been outlined above.

## 1.5 Terms of Reference and Timescales

- 1.5.1 The specific terms of reference agreed for this review were:
- Was there any history of either the victim or alleged perpetrator having experienced or perpetrated domestic abuse in previous relationships? Consider how this may provide context for this review and help to understand events that occurred leading up to this homicide.



- Were practitioners knowledgeable about potential indicators of domestic abuse and aware of what to do if they had concerns? Were there any indicators or disclosures of domestic abuse in this case? Were they recognised and acted upon appropriately?
- What were the key points or opportunities for assessment and decision making in this case? Did the agency have specific risk assessment tools for domestic abuse? Were assessments used correctly and do decisions appear to have been reached in an informed and professional way?
- Were appropriate risk management actions identified and undertaken as a result of assessments? As this case was not subject to the MARAC process consideration should be given as to whether it should have been instigated.
- Were there any concerns relating to substance use or mental health issues in the case of either the victim or alleged perpetrator? Were these acted upon appropriately? In what way may these have impacted in relation to any domestic abuse, or the responses by agencies? *Consider if the interplay between domestic abuse, substance use and/or mental health issues, may have led to any 'narrowing of focus' and the failure to explore other issues.*
- Were practitioners sensitive to the needs of the victim, the alleged perpetrator, and any others involved? Had any disclosures been made and if so, were the responses appropriate? *This should include where any disclosures to family and/or friends were shared with agencies.* When, and in what way, were the victim's wishes and feelings ascertained and considered. Was the victim informed of options/choices to make informed decisions and were they sign-posted to other agencies? *Consider whether the gender of the victim may have impacted upon responses to any disclosures made and the offering and availability of support; as well as to whether there was any indication of the victim having been isolated by the alleged perpetrator, or being subject to coercive control, and how this could have impacted upon him accessing services or disclosing to agencies.*
- Did any concerns relating to the victim/alleged perpetrator lead to wider referral/assessment of the family? If not, are there indications that they should have done so?
- Were there any concerns relating to the children? Did these lead to consideration of domestic abuse issues? If not, are there indications that they should have done so?
- Did the agency have policies, procedures or protocols (including information sharing) in place for dealing with concerns about domestic abuse and were these complied with?
- Did practitioners have appropriate levels of training and awareness to allow them to fulfill all the above expectations?
- Were procedures sensitive to the ethnic, cultural, linguistic and religious identity of the victim, the alleged perpetrator and their families? Was consideration for vulnerability and disability necessary and, if so, was it responded to appropriately?
- Were senior managers or other agencies and professionals involved at the appropriate points?

- To what degree could the homicide have been accurately predicted and prevented?
- 1.5.2 The Panel agreed that the primary time period over which events should be reviewed should be from 1<sup>st</sup> January 2010 to the day of the homicide. This date was agreed upon as the information shared suggested that was approximately the date at which the relationship between Mark and Ms K began.
- 1.5.3 It was also confirmed that any relevant and significant events prior to this review period should be included within IMRs should they provide context to the homicide, the risk posed by the alleged perpetrator, or the vulnerability of the victim or children.
- 1.6 Profiles of Agencies who completed IMRs and their Methodology**
- 1.6.1 As part of the review process Individual Management Review (IMR) reports were completed by seven agencies where it was identified that significant contact had taken place with Mark or Ms K within the specified time period. All IMR authors were independent of the case and had had no contact with either party, either as a practitioner or through the management of staff involved. IMR reports were received from the following agencies:
- Northumbria Police
  - National Probation Service, North East Region (NPS)
  - Newcastle Gateshead Clinical Commissioning Group (CCG)
  - Newcastle upon Tyne Hospitals NHS Foundation Trust (NUTH)
  - Northumberland Tyne and Wear NHS Foundation Trust (NTW)
  - Northumberland County Council Children’s Services
  - ESCAPE Family Support
- 1.6.2 **Northumbria Police** serves a population of 1.5 million people and covers an area from the Scottish border down to County Durham, and from the Pennines across to the North East Coast.
- 1.6.3 The IMR for Northumbria Police was undertaken by the Major Crime Review Advisor, and was quality assured and approved by the Detective Chief Inspector, Protecting Vulnerable People. In order to complete the review the author examined incident logs, arrest records, domestic abuse, child concern and intelligence records. Interviews also took place with two police officers from the Neighbourhood Policing team, as well as two Training Officers.
- 1.6.4 The **National Probation Service (NPS)** is a statutory criminal justice service that supervises high-risk offenders released into the community. It was established on 1<sup>st</sup> June 2014 along with 21 Community Rehabilitation Companies (CRCs). Together the NPS and CRCs have replaced the former Probation Trusts.

- 1.6.5 The IMR for NPS was undertaken by the Safeguarding Communities Manager, National Probation Service, North of Tyne Cluster, on behalf of the National Probation Service, North East Region. For the purpose of the IMR two Offender Managers were interviewed (who at different points had responsibility for the supervision of Mark's Order), and all available records and assessments scrutinised.
- 1.6.6 **NHS Newcastle Gateshead Clinical Commissioning Group (CCG)** is a statutory organisation responsible for the planning and buying of local NHS care and services to meet the needs of the local community across Newcastle Gateshead.
- 1.6.7 The IMR for the Newcastle Gateshead CCG was undertaken by the Lead for Adult Safeguarding, and reviewed by the Medical Director of the CCG. In undertaking the IMR the author reviewed the General Practice records of Mark and Ms K, who were known to different practices, as well as undertaking an interview with Mark's usual General Practitioner (GP), and a practice nurse who saw Ms K shortly before the homicide.
- 1.6.8 The **Newcastle upon Tyne Hospitals NHS Foundation Trust (NUTH)** is one of the largest NHS Trusts in the UK and delivers healthcare services from six sites within the Newcastle area.
- 1.6.9 The IMR author for NUTH works as a Senior Health Advisor and takes a lead role within a clinical service providing safeguarding advice and supervision to other practitioners. The author was supervised by the Named Nurse for Adult Safeguarding, and the report was quality assured and approved by the Head of Nursing. The report was written following a review of Mark and Ms K's paper and electronic medical records. For the purpose of this review additional Newcastle Hospitals medical records of Mark's ex partner, Ms A, were examined. They contained nothing the IMR author felt was relevant for disclosure to this review process, and also occurred prior to 1<sup>st</sup> January 2010, outside of the time frame set within the Terms of Reference for this review.
- 1.6.10 **Northumberland, Tyne and Wear (NTW) NHS Foundation Trust** is one of the largest mental health and disability trusts in England. It works from several sites across Northumberland, Newcastle, North Tyneside, Gateshead, South Tyneside, Sunderland and North Easington and serves a population of 1.4 million.
- 1.6.11 The IMR for NTW was undertaken by the Deputy Head of Safeguarding and Public Protection, who consulted with and was supervised by the Head Safeguarding and Public Protection within Northumberland Tyne and Wear NHS Foundation Trust. In order to prepare the IMR the author reviewed the Trust's paper and electronic records for all family members, and interviewed one staff member.

1.6.12 The IMR for **Northumberland County Council (NCC) Children’s Services, Health and Community Wellbeing Directorate** was undertaken by a Children’s Services Senior Manager. The IMR author was supervised by the Head of Safeguarding and Looked After Children, who approved and quality assured the report.

1.6.13 The IMR for **ESCAPE Family Support** was undertaken by the Family Team Manager / Safeguarding Children Officer, and was supervised and approved by the Chief Executive Officer. The IMR was completed by consulting the case file of Ms H. No staff were interviewed as part of the process as Ms H’s allocated keyworker is deceased.

## 1.7 **Family Input into the Review**

1.7.1 Mark’s parents were contacted at the start of the review to advise them of the process, and explain that their input would be most welcome and useful should they wish to be involved. They identified at that time that they felt they had nothing to contribute to the process but were happy to be contacted once more following the conclusion of the criminal process. At this stage Mark’s parents were once more spoken with but reiterated that they did not feel they wished to add any information to the review. They said they wished to put events behind them and did not feel there was anything agencies could have done to prevent the death of their son. Respecting their wishes, no further contact was made until the completion of the review to offer them sight of the final report and seek their comment upon this. Mark’s sister was also invited to take part in the review but declined to do so via the Family Liaison Officer.

1.7.2 Ms A, the ex-wife of Mark and mother of his son, was also informed of the review process. She felt that as her relationship with Mark had ended some years before she had nothing she wished to contribute to the review, but advised that she was happy for any relevant information that may come to light to be used within the review.

1.7.3 Ms K’s ex-partner and father of her child declined to be involved with any processes linked to the death of Mark.

## 1.8 **Other Information used to inform the Review Process**

1.8.1 Discussion also took place between the Chair of the Review / Overview Report author and Northumbria Police’s Senior Investigating Officer in the case. As a result of this the Chair was also given sight of papers from the criminal investigation, which are referenced where relevant within this report.

1.8.2 This information also led to an interview with Ms K’s manager from her previous employment. In this meeting Ms Z identified that she no longer worked for the company where she had been Ms K’s manager. Due to the concerns raised by

Ms Z in relation to her employer's response to Ms K's experience of domestic abuse, and the support for Ms Z in dealing with this, attempts were made to contact them, gain their perspective, and involve them further in the review. However no contact could be established, and it then came to light that they were no longer involved in running the service for which Ms K had worked.

1.8.3 While the information provided to this review by Ms K's former manager is considered both in providing context for the homicide, as well as in relation to the practice within the company for which she worked, the decision was taken by the Panel not to name the company within this report, as they had not had the opportunity to respond to the specific issues identified. However one of the recommendations arising from this review is to share the findings in order that the company consider them in relation to ongoing practice.

1.8.4 It was also agreed by the Panel that the Chair of the Review / Overview Report author should meet with the perpetrator in this case, Ms K. This interview took place following the conclusion of the criminal process.

## 1.9 Criminal Process

1.10 In January 2015 Ms K pleaded guilty to the manslaughter of Mark. Adjournment occurred for the preparation of psychiatric reports from which it was agreed that Ms K had amnesia in relation to her commission of the offence. She was sentenced to seven years imprisonment.

## 1.11 Coroner's Inquiry

1.11.1 No additional information from the Coroner's Inquiry was used to inform this review process.

## 1.12 Other Parallel Reviews or Processes

1.12.1 No other parallel review processes were identified as taking place in relation to the death of Mark.

## 1.13 Confidential Information and Consent.

1.13.1 Consent was sought and granted by Ms K for agencies to review and share information from her records in relation to this review.

1.13.2 Attempts were made via Northumbria Police to contact Ms K's ex husband Mr C regarding the review process, however he expressed that he wished no further contact in relation to the death of Mark or his relationship with Ms K. As a result agencies were unable to get consent regarding review of any records relating to his daughter with Ms K. Without this consent Northumberland County Children's Services considered the information known to them and shared some limited information, which they considered to be relevant to the

review process and within the public interest.

- 1.13.3 Any information relating to other parties was shared by agencies where it was felt to be in the public interest.
- 1.13.4 In line with Home Office Guidance for the completion of DHRs, full consideration was given to the need to anonymise or redact any necessary information prior to publication.

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## **CONCLUDING REPORT**

### **2 THE FACTS**

#### **2.1 Circumstances of Mark's death**

2.1.1 At the time of his death Mark was living with Ms K. On the day of his death in March 2014, Ms K made a 999 call made to the North East Ambulance Service reporting a stabbing. When the paramedic crew arrived the police were already on scene and Mark was found with a knife wound to the left side of his shoulder. The two attending crews and the rapid response paramedic found no other injuries.

2.1.2 Mark later died as a result of the stab wound and Ms K was charged with his murder. She later pleaded guilty to manslaughter and was sentenced to seven years imprisonment. Following the preparation of a psychiatric report, it was accepted by the court that she had amnesia in relation to her commission of the offence.

#### **2.2 Family structure and background**

2.2.1 Mark and Ms K were both of White British origin, with English as their spoken language. Information available to the review indicates that Mark and Ms K had been in a relationship since early 2010, with reference within housing records to a shared address since June 2010. They had no children together.

2.2.2 Mark had been married previously to Ms A, with whom he had a son (Sam), born in 2007. Agency records indicate that the relationship broke down around the time of the pregnancy, and there were reported concerns by Ms A around Mark's abusive behaviour and drug use. Following this separation, Sam was in the full time care of his mother and it appears that Mark had limited contact.

2.2.3 Reference in police records is also made to Mark having had a subsequent significant relationship with Ms B prior to entering into a relationship with Ms K.

2.2.4 Ms K was married previously to Mr C and they had a daughter (Donna), born in 2000. Records suggest that this relationship ended in approximately 2008. Mr C and Ms K are both believed to have parental responsibility for Donna, however at the time of Mark's death Mr C appeared to have had full time care of her for approximately six years.

2.3 **Agencies involvement with the couple**

2.3.1 As has been outlined previously, six agencies were originally identified as having had sufficient contact with Mark and Ms K to warrant the completion of a chronology and Individual Management Review (IMR), with a seventh agency (ESCAPE) being asked at a later stage to complete an IMR. A full composite chronology of all these agencies involvement was compiled to assist in the review process. Below is a summary of the extent and nature of agencies' contact.

**Relevant contact with agencies prior to the review period**

Mark

2.3.2 The IMR for Newcastle Gateshead CCG identified that Mark had no relevant medical history until 2006. In November 2006 records indicate that he presented with low mood due to the breakdown of his marriage whilst his wife (Ms A) was pregnant. He was seen on several occasions until March 2007 and was prescribed an antidepressant. During this time his son Sam was born and it was recorded that although the situation was difficult, his mood improved. In July 2007 a member of staff noted that Mark's wife alleged that he used cocaine and had 'unpredictable' behaviour. No further action or exploration was taken as a result of this. Further concerns by Ms A around Mark's behaviour were also noted within the children's health records.

2.3.3 During the above period Northumbria Police reported two domestic incidents in relation to Mark and Ms A. The first of these, in June 2007, was recorded as a verbal altercation. Their son Sam, who was approximately three months old at this time, was not present during the altercation, however a Child Concern Notification (CCN) was sent to Children's Services. The following month, July 2007, Ms A reported harassment from Mark, for which he was arrested and received a caution. A further CCN was sent to Children's Services. Newcastle Children's Services received both these CCNs and as no significant direct risk to Sam was identified, they were responded to by a letter offering support to Ms A. There was no subsequent involvement of Newcastle Children's Services following this.

2.3.4 At an appointment in June 2008 Mark complained to a GP (Dr B) about having had paranoid ideation for approximately six months. He described thoughts that his partner was having an affair, although he stated that he knew that this was not the case. It would appear that the partner to whom he referred was probably Ms B. He also noted during this appointment that he occasionally used cocaine. Mark was referred to mental health services and received a letter asking him to make an appointment, but there was no evidence in GP records that he did so.



- 2.3.5 In December 2008 Northumbria Police received a call relating to a disturbance between Mark and his then partner, Ms B. They were reported to have been located in the street, both under the influence of alcohol. There had been a verbal dispute, and Ms B stated that Mark had pulled her by the hand. There were no injuries and Ms B would not make any statement; as a result no action was taken against Mark.
- 2.3.6 A further incident took place in March 2009 when a report of a disturbance was received. On attendance Mark was no longer at the premises, but Ms B had bruising to her face and stated that he had punched her. Mark was arrested and charged with Assault Occasioning Actual Bodily Harm. He pleaded guilty to this offence and in April 2009 a Pre-Sentence report was prepared by the Probation Service. The risk assessment tools used by the Probation Service included a specific domestic abuse assessment, and as a result of this it was identified that Mark was both suitable and eligible for the Community Domestic Violence Programme. He was subsequently made subject to an 18 week custodial sentence, suspended for 24 months. The Suspended Sentence Order included supervision and a requirement to attend the Community Domestic Violence Programme. As is standard practice a 'CDVP2' form was also submitted to the Police. This form notified Police that an Order had been made and required that Police should notify the Offender Manager in the event that any new domestic incidents were reported; the offender was arrested; any other police investigation came to notice; or there were any known changes to the victim's address. Mark was then scheduled to commence CDVP in September 2009, and pre-group work began with him on a one to one basis at his weekly Probation appointments. At this time Mark reported that he was living with his parents and had no ongoing contact with Ms B, the victim of the assault.
- 2.3.7 In April 2009 Mark's parents spoke to a GP (Dr A) expressing concern about his mood swings and excessive alcohol consumption. He was said to have a previous cocaine problem. They were also concerned that he was not eating, and was losing weight. They were advised to encourage Mark to make an appointment and he attended the same month and saw another GP (Dr D). Excessive alcohol consumption of three cans of 'Strongbow' per day was noted, along with occasional cocaine use. Mark spoke of deep seated sadness for ten years but did not know the reason for this. He also reported that he was awaiting sentencing for common assault, which would appear to be that outlined above relating to Ms B. He was given contact numbers for self-referral to Plummer Court and NECA.
- 2.3.8 In May 2009 Mark's father contacted the GP out of hour's service as Mark had visited his parents' home. He was aggressive and throwing bricks at windows. Advice was given that they should call the police if necessary, and that it was not appropriate to send a GP due to the potential dangers.

- 2.3.9 The IMR completed by NTW identified that in May 2009, Mark made a self referral to Plummer Court addiction services, expressing concern about his use of cocaine and alcohol. He stated he was not using daily but that when he did use it was 'a lot'. He also reported that under the influence he became violent and aggressive. He requested help to stop using substances. A subsequent assessment appointment was arranged for June 2009.
- 2.3.10 During the assessment at Plummer Court, Mark described a ten year history of cocaine use. He reported using a 'gram' of cocaine on average at weekends, resulting in him spending £200 over two nights. He stated that when cocaine was available he found it difficult to refuse, and reported 'snorting' the cocaine. Mark described physical symptoms of lethargy on the days following his cocaine use, which was considered normal for such use. He also stated that he used between 4 to 5 pints of lager on Friday and Saturday nights, however the amount of alcohol could increase if he was using cocaine. Mark stated that once under the influence of both alcohol and cocaine he 'lost track' of how much alcohol he consumed. The pattern of both cocaine and alcohol use was reported to be repeated most weekends. Mark denied any other substance use and did not present or describe withdrawal symptoms. Drug screening carried out at assessment was only positive for cocaine.
- 2.3.11 A social history was also taken during the above assessment, and Mark reported that he was living with his parents who were aware of his drug use, and were very supportive of him. He also stated that one month previously he had separated from a relationship, which had been ongoing for 14 months. It would appear from other information provided by agencies within the review that he was referencing his relationship with Ms B. He cited his cocaine use as a factor in the breakdown of this relationship. He also informed the assessor that he had a son from a previous relationship who was approximately three years old, although he could not recall his exact date of birth. He stated he had no ongoing contact with his son at that time.
- 2.3.12 The mental health and risk assessment that was completed indicated that Mark had had no formal contact with mental health services other than this assessment. He reported sleep problems in approximately 2006 for which his GP prescribed Trazadone for 2 to 3 weeks. Mark was ambivalent about how effective this treatment was. He described his current mood as 'down in the dumps', stating he felt like he had 'a grey cloud hanging over him', and reported that he had felt like this for a number of years. He also spoke of poor appetite and weight loss. Mark stated that people around him were concerned about his attitude, saying he was becoming more volatile. Within records he was described as having good insight into his cocaine use and of having previously managed a two month period of abstinence where his mood improved. The harmful effects of cocaine and alcohol use were discussed with him.
- 2.3.13 Mark described having had fleeting thoughts of suicide in the past, but stated he would never act on these thoughts. He denied any current suicidal ideation, citing his family and friends as a protective factor.

- 2.3.14 A summary of the assessment noted that Mark acknowledged his cocaine use to be problematic, stating that 'it has been a massive issue for so long'. He stated he wanted to be able to get up in the morning and be happy. He saw his alcohol use as only a problem when he was under the influence of cocaine. Mark was also aware of the positive and negative effects financially, socially and emotionally. He was signposted to Lifeline for support from the 'Stimulant Clinic' who would address alcohol use, and discuss and offer Blood Borne Virus screening and vaccinations if necessary. A formal risk assessment was undertaken and no concerns were raised regarding any risk to others.
- 2.3.15 Following the above appointment Mark's GP was sent a letter outlining the assessment and its outcome, and Mark was discharged from Plummer Court in July 2009. There is no evidence that he followed up the appointment with Lifeline.
- 2.3.16 In August 2009, having maintained contact with the Probation Service since the start of his Order, and undertaken pre-group work to prepare him for the Community Domestic Violence Programme, Mark reported that he would be temporarily moving to Glasgow for work, but that he did not know where he would be staying. Arrangements were made for him to report to Glasgow Social Work Office, and he was at this stage withdrawn from the September CDVP group, with a view to him being re-referred when he returned to Newcastle.

Ms K

- 2.3.17 Prior to the period of the review Ms K appears to have had limited relevant contact with agencies, and was not at this time in a relationship with Mark. However the limited information that has been provided suggests problems in relation to alcohol use and depression, as well as difficulties in her marriage to Mr C.
- 2.3.18 Ms K gave birth to her and Mr C's daughter in November 2000, and there is then no relevant agency contact until 2007, when there was a 'contact only' record with Northumberland Children's Services on 07/12/07. This related to a referral which stated that Ms K had been screaming at her home address, whilst her daughter Donna had been at school, and that she had attended hospital due to concerns about suffering from possible depression. This was dealt with as a contact only with grandparents, as Mr C was caring for Donna and no further action was felt to be needed by Children's Services. Later in December 2007 Ms K was taken to Wansbeck Accident and Emergency Department after her mother became concerned for her welfare and police broke into her home. Ms K reported to the hospital that she had been drinking heavily for two years and that her husband had lost his job three months before. She was prescribed an antidepressant, and given details for self-referral to ESCAPE for help with reducing her alcohol consumption. A referral was also made to Children's Services and an Initial Assessment completed. Within this Ms K reported that this was a one off incident due to stress around depression, employment, and

finance issues. There was felt to be no further role for Children's Services at this time.

- 2.3.19 Following the above, there is no further contact by Children's Services until one year later, when on 08/12/08 Mr C contacted the Northumberland County Council's Emergency Duty Team for advice around preventing further contact between Ms K and their daughter Donna. It was confirmed that Donna was in his full time care. He advised that there had been an incident in which Ms K had gone missing and when he found her, she had lashed out at him, biting his arm and scratching his face. He also advised that she had previously lashed out at her own parents. Donna was ascertained to be safe in Mr C's care and no further action was needed, other than the advice given around contact.
- 2.3.20 There is also a period of contact by Ms K with ESCAPE Family Support from May to August 2009; this was in relation to her alcohol use.

#### **Review Period**

- 2.3.21 The period covered by this review was from 2010, as this is when agency information indicates that Mark and Ms K's relationship began. There is however within this period a further incident reported by Northumbria Police involving Mark and Ms B. This occurred in February 2010 and was recorded as a verbal argument. No offences were disclosed and Mark is reported to have left the premises when requested. There is no indication that this incident was notified to Probation despite Mark being on an Order related to an offence of violence against Ms B, and Probation having submitted the CDVP2 form at the start of the Order to notify Police of this.
- 2.3.22 At the beginning of 2010, Mark continued to be subject to Probation Supervision. However, following his report in August 2009 that he was moving to Glasgow for work, the nature of his contact became limited, as he reported that he was working away at various locations during the week. None of this was verified beyond his self report. In total from August 2009 to the end of his order in April 2011 Mark was seen a total of 15 times, averaging once a month. However, only 8 of these appointments were with his Offender Manager, with the remaining 7 involving him reporting to duty officers. In February 2010 consideration was given to whether the CDVP requirement of Mark's supervision should be revoked due to his reported work commitments, with this finally occurring in November 2010.
- 2.3.23 Due to the limited nature of Mark's contact, as outlined above, no focused work was undertaken during this time regarding either his domestic abuse or his substance use problems, instead focus was on attempting to maintain some level of contact. In addition no home visit was undertaken during this time and Mark reported that he remained living with his parents and did not disclose being in a new relationship. Furthermore Probation were unaware of the incident with Ms B that took place in February 2010. While risk assessments

and supervision plans were regularly reviewed, these appear to have been based solely on information self-reported by Mark.

- 2.3.24 In March 2011 Mark was arrested for Driving Whilst Under the Influence of Alcohol. When discussing this with his Offender Manager he reported that he had an argument with a girlfriend who lived in Ashington and he was driving back to Newcastle. His Offender Manager expressed concern that this relationship had not been previously disclosed. Mark then backtracked saying it was 'nothing serious; and was 'only casual'. The Offender Manager had hoped to pursue this further with Mark in preparation of the Pre-Sentence Report relating to his driving offence. However, on 05/04/11, the Court sentenced without such a report, imposing a Community Order with 200 hours unpaid work. Mark's previous Supervision Order then expired on 21/04/11, and he is reported to have completed his unpaid work without incident.
- 2.3.25 In relation to Ms K, during the above time period, in April 2010 there was a brief intervention by Northumberland County Council's Children's Services. This was a 'Provision of Information and Advice' contact, following Mr C seeking advice and guidance around contact issues due to Ms K's reported alcohol use. Information provided at this time indicated that Ms K had moved to live with her parents, and there was an incident where she had been drunk and attacked Mr C in front of their daughter Donna. Mr C was reported to be clear that this was unacceptable, and to have subsequently removed their daughter from the situation. He was appropriately sign posted to childcare solicitors and there were felt to be no concerns regarding the safety of Donna, who was in his full time care.
- 2.3.26 Following the above, the next relevant contact with agencies was in July 2010 when Ms K contacted her GP reporting that she had stopped drinking and was experiencing shaking. She was referred to Wansbeck Accident and Emergency Department. She gave a three-year history of heavy drinking which had escalated to three bottles of wine per day. She was sent home from Accident and Emergency with instructions to see her GP. She did this four days later when she confirmed that she had not had any alcohol for five days and that she had arranged an appointment with ESCAPE. Information from ESCAPE confirmed that Ms K was in contact with them from May 2010 until March 2011, when she received received one to one support from an allocated Drug and Alcohol Support Worker.
- 2.3.27 Ms K had no further contact with her GP until November 2011 when blood tests taken at a private clinic (possibly for an occupational medical) showed abnormally large red blood cells. She was sent a letter about this by her GP, and further blood tests were arranged, that came back normal. It was noted in the CCG IMR that large red blood cells can be caused by excessive alcohol consumption, but that there was no record of this having been discussed with Ms K.

- 2.3.28 During the period of the review there were two domestic abuse incidents recorded between Mark and Ms K, both in 2012. On the first occasion, in January 2012, police reports indicate that both parties were under the influence of alcohol and Ms K reported that there was a verbal altercation when she woke Mark up. Although Mark had some slight scratches on his face he refused to account for them or make any complaint. A mirror had been broken, however Ms K confirmed there had been no assault. On this occasion Ms K was assessed a standard risk. She was offered a victim referral, which she declined.
- 2.3.29 At the second incident in December 2012 Ms K reported problems with Mark, stating they had been fighting. On police attendance both were believed to be under the influence of alcohol, and it was recorded that there had been a 'heated' verbal argument during which both parties had hit out at each other. Mark was arrested to prevent a breach of the peace. An officer returned to take a statement from Ms K, however while she showed the officer her bruises, she refused to attend court, therefore Mark was released without charge. Ms K was assessed as being at medium risk and was passed to the Neighbourhood Policing Team for management, where she signposted to other agencies and advised regarding personal safety and safe methods of contacting police and other agencies.
- 2.3.30 Following the above there is no further involvement of the police, however both Mark and Ms K continued to have contact with health services.
- 2.3.31 In September 2012 Ms K attended Newcastle Hospitals with a fractured finger, reporting having trapped her finger in a safe at work. This was dealt with medically and there was nothing to suggest that the injury was not consistent with the reported cause.
- 2.3.32 In January 2013 Ms K registered with a new GP practice and had a new patient check with the nurse. She admitted to a previous alcohol problem but said that she now drank only one or two drinks on special occasions.
- 2.3.33 In February 2013 Mark saw a GP (Dr B) and complained of stress at work as he had been "pulled up for work done". He reported that he lived with his girlfriend and that the stress was affecting his home life, where he was angry. This was not explored further. He complained of an irregular sleep pattern and said he had tried herbal medication to help him sleep. He also reported consuming 4 'cans' at times and was noted to smell of alcohol when seen. His concentration was good and there was no evidence of thoughts of self-harm. He was reported to be lethargic and worried that he might have diabetes. Blood tests were taken and showed large red blood cells, abnormal liver function tests and a high ferritin level (iron stores). He was given contact details for Talking Therapies. Dr B wrote to him about the abnormal blood tests and they had a telephone discussion in March 2013. Mark reported taking double the recommended dose of supplements and body building medications. He was advised to stop and to have repeat blood tests. These were not completed.

- 2.3.34 In March 2013 Ms K was seen by an out of hours GP because of bruising. She was sent to The Royal Victoria Infirmary for assessment and was subsequently seen in the Haematology Department. No evidence was found of a bleeding disorder but her red blood cells were again found to be large. There is no suggestion that the bruising was due to trauma. This is the sole incident the IMR author for Newcastle Hospitals identified as relevant in relation to Ms K's contact with them. During this attendance on the Assessment Suite at the RVI, Ms K was noted to be upset by the nurse caring for her as she reported that she had had an argument with her partner. The nursing records do not indicate that the nurse witnessed the argument, or specify whether it occurred in person or by telephone. The nurse deferred taking the routine observations due to Ms K's upset.
- 2.3.35 In November 2013 Mark consulted Dr B and reported excessive drinking for two years. He said this had started out of boredom but was now a problem. He had reduced appetite and weight loss. He was given contact details for NECA but he did not attend.
- 2.3.36 In February 2014 Ms K saw a Nurse Practitioner (Nurse J) at the surgery. Nurse J was carrying out a GP type surgery with 10 minute appointments. Ms K was distressed and crying. She described a lot of stress and financial difficulties. She was on a probationary contract at work, but having taken a few days off to get the boiler fixed at home was concerned she would be dismissed. She described panic attacks. The nurse documented there was no alcohol dependency, no substance abuse and no thoughts of self-harm. She described low self-esteem and her family were noted as a protective factor. Domestic violence and abuse was not disclosed or enquired about. Ms K was prescribed an anti-depressant and asked to come back in five weeks.
- 2.3.37 Ms K had no contact with mental health services until she was seen by a Criminal Justice Liaison Nurse while in Magistrates cells following the murder of Mark. Her case was opened because of possible risks to herself during the judicial process. Ms K engaged with the Liaison Nurse whilst in the cells and was reported to appear to be in shock at her situation. She stated she felt 'numb'. She described her mood as low and felt this was related to her frequent use of alcohol. She said she recently received a prescription from her GP for antidepressants but did not think this was working yet. She denied any feelings of self harm or suicidal ideation, but said she did not know how to feel under the circumstances. She did state that when she was released she had intentions of getting access to the strongest medication in order to take an overdose, which seemed to contradict the assertion that she had no feelings of self harm or suicidal ideation. Ms K also stated she had been living with her partner and had a stable employment, however due to her alcohol use was due to attend a disciplinary. She described ongoing domestic issues with regards to financial pressure and alcohol use.

- 2.3.38 The last contact by Northumberland Children’s Services was on 10 March 2014 in response to the Police notification of the arrest of Ms K. Mr C was contacted and confirmed that Donna had had very little contact with Ms K over the past 6 years. He was aware of the incident with Ms K and her partner in Newcastle, but did not want any involvement of Children’s Services.

### **3 INTERVIEW WITH MS K**

- 3.1 Ms K agreed to meet with the Chair/Overview Report author in order to assist the review process. While it was acknowledged by the Panel that Ms K was the perpetrator in this case, it was also felt that her own history as a victim of abuse needed to be considered in relation to the events that subsequently occurred.
- 3.2 During interview Ms K continued to report amnesia relating to the assault, as was accepted by the Court. She did however express extreme regret and wished to make it clear that nothing could excuse or mitigate the actions she had taken in causing the death of Mark. She appeared very keen not to portray Mark in a bad light and in relation to abuse spoke of them ‘being as bad as each other’.
- 3.3 In discussing their relationship however Ms K did gradually reveal having been the victim of a high level of abuse that included, according to Ms K, Mark having held a gun to her head, strangled her, and threatened her with ammonia. She also spoke of often being covered with bruises, and how she felt Mark deliberately targeted areas of her body to ensure the bruises would not be visible. It is of note that following the homicide a handgun was found in the home of Mark and Ms K.
- 3.4 Ms K disclosed a specific incident of relevance to this review, that which took place in September 2012 when she attended hospital with a fractured finger, having reportedly trapped her hand in a safe door at work. Ms K said that on this occasion Mark had broken her finger deliberately, by forcing her fingers apart. She stated that he did this, as he knew it would stop her from being able to work.
- 3.5 Ms K described the abuse she experienced as beginning approximately six months into her relationship with Mark, when he moved in with her. In the author’s experience of assessing and working with both perpetrators and victims of abuse, Ms K’s presentation was indicative of someone who had been subject to a high level of abusive and controlling behaviour, and she demonstrated significant levels of self-blame. Ms K spoke of how during her relationship with Mark she was ‘not living just existing’ and how as a result of the level of violence she started to ‘fight back because (she) had to’. As to what this involved she described a use of low level defensive violence including scratching and hitting. In retrospect she said she should have walked away instead of fighting back, but that Mark had threatened to have her killed if she



left, a threat she believed was credible. In addition to the fear, Ms K described having wanted to help Mark, and believing she could help him to change.

- 3.6 Ms K also spoke of her alcohol use as a means of coping and said this had begun in her previous relationship with Mr C, whom she described as possessive and controlling. She spoke of feelings of shame that she was experiencing abuse and how she used alcohol to mask these.
- 3.7 As regards her contact with agencies, Ms K said she was keen to hide her abuse and would not accept help that was offered. She said that while she would call the police at times of increased fear, she would then deny that anything occurred. Similarly, she spoke of covering up the abuse within contact with health services.
- 3.8 Ms K identified that her family, her employers, and friends at work, were aware of the abuse due to having seen her with bruises. She spoke of making light of things when she presented with injuries, and telling people that she was ‘just as bad’ as Mark. In reality however she said that her own violence was defensive, as she believed it was the only means of protecting herself. Within these situations she identified that family, friends and colleagues had offered help and signposted her to other agencies, but that she had not been ready to take this step. She said she was aware of where she could get help but had not done so, as this would have meant acknowledging that she was experiencing abuse.
- 3.9 Ms K did report accessing help in relation to her alcohol use through ESCAPE, and said that she found the counsellor there to be extremely supportive. She acknowledged though that at that point in time she had not been ready to give up alcohol. While she had found it helpful emotionally to go and talk to the counsellor, she would often do so with alcohol in her bag, knowing she would go and drink after seeing them.
- 3.10 In relation to the way that services could be improved, Ms K said that she did not feel there was anything more that could have been done within her contact with agencies. However she went on to identify that had she been fully aware of Mark’s abuse towards his ex-partner this may have helped her to acknowledge the abuse she was experiencing herself. She also spoke of the need to educate young children around issues of abuse, and the need for people to talk about things instead of keeping them hidden.

#### **4 INFORMATION FROM OTHER SOURCES**

##### **4.1 Information from Ms K’s manager**

- 4.1.1 In a witness statement provided to the Police from Ms K's manager at the company where she was working prior to the homicide, the manager, Ms Z, stated that Ms K had presented at work with bruising to her eye in December 2013 and had reported that this was a result of having been punched in the face by Mark. She refused offers of support, or for police or medical services to be contacted. As in Ms K's account, her employer recalled that Ms K had said that her and Mark had both been violent towards each other in the past.
- 4.1.2 As a result of the above Ms K's manager was contacted to ask if she would participate in the review so that more information could be sought regarding Ms K's presentation at work and any response by her employer. Ms Z agreed to meet with the Chair/Overview Report author and a representative of Safe Newcastle. In this meeting Ms Z identified that she no longer worked for the company where she had been Ms K's manager.
- 4.1.3 In discussing Ms K, Ms Z described her as 'lovely' and someone who presented as though she 'wouldn't hurt a fly'. She said that she had concerns that there were difficulties at home in the year leading up to the homicide, and that Ms K presented as depressed and spoke of financial difficulties. She described how Ms K never came to nights out except on one occasion, during which Mark called her and then came to pick her up early. Ms Z said that she had a 'gut instinct' that Ms K was experiencing some form of emotional abuse; she spoke of Ms K reporting that Mark had money but that she herself had nothing; of her having a panic attack one day at work; and of her once turning up to work under the influence of alcohol which was unusual, despite being aware that Ms K had alcohol problems outside of work. However, Ms Z reported that it was not until Ms K's presentation with a black eye that she became aware that there was any physical abuse within her relationship.
- 4.1.4 Ms Z said that the primary presenting problem at work was Ms K's repeated failures to attend without contacting them to explain why. She described how she would call Ms K to see why she was not present, but that she would not always receive a response. As part of disciplinary procedures within the company, letters were sent home when Ms K failed to show at work without explanation. Following the first of these Ms K had informed Ms Z that her and Mark argued over the letter. It was then following the second one that Ms K presented with a black eye; Ms Z felt the letter may have contributed to the situation that led to this. As a result she felt it was no longer appropriate to send the letters home, as per Human Resources procedure, so she then started to give them to Ms K in person.
- 4.1.5 During the above period, Ms Z also said that she did not think the disciplinary route was appropriate but that this was not her decision. She said that as a manager she had received no training for her role, and had not feel supported in addressing issues or implementing disciplinary action. In addition there was no clear procedure to follow and no HR representatives within disciplinary

meetings. Furthermore she was not aware of any domestic abuse policy or procedure in place to assist in relation to her concerns about Ms K. She described how she attempted to avoid, where possible, formal disciplinary steps to assist Ms K and prevent her losing her job. During meetings she also passed on details of the organisation's counselling service, as well as discussing other options with Ms K such as discussing with family and friends, seeing her GP, or, following her presentation with a black eye, contacting the police. She spoke of this action being taken by her as an individual and not having received any guidance by the company. Ms Z also described having subsequently received no support from the company following Mark's death, and Ms K's arrest for his murder.

## 4.2 Information from witness statements

4.2.1 As part of the review process the Police's Senior Investigating Officer shared witness statements gathered as part of the criminal investigation. These were reviewed in order to provide additional background and context.

4.2.2 Included within these statements were those given by Mark's father, mother and sister, all of whom spoke of concerns regarding the relationship between Mark and Ms K. Among the incidents of physical violence was an incident when Mark reported that Ms K had stabbed him in the knee and he was seen to have a half inch gouge in the side of his knee, as well as a bite mark on his thumb. Mark's sister also described how, in September 2013, Mark had told her that Ms K had broken his nose. She noted no black eyes or marks, which made her think that it must have happened a few weeks before, as around this time Mark had started to talk nasally. She also observed him to have scratches to the side of his face, ear and jawline, which were scabbed and appeared to be old.

4.2.3 In early 2014 Mark's father attended the home and Mark showed him his thumb, which he reported Ms K had bitten; Mark's father observed bite marks which appeared to be a few days old. Ms K was also seen with bruising to her eye on this occasion. Ms K and Mark then began to argue and in the course of this Ms K 'launched herself' over the sofa and attempted to scratch Mark's face. Mark's father reported a total of three incidents in 2014 when Mark had rang him and asked him to collect him after he and Ms K had argued.

4.2.4 In February 2014 Mark's mother also described an incident when she called to the home and Mark was sitting on the living room floor. She asked him why and he told her that 'he wasn't allowed to sit on the sofa as it was Ms K's house and her brother had given her the sofa'. Mark's mother stated that this was cruel, to which Ms K said 'well he never cuddles me anymore'. Mark then told his mother that Ms K had pictures of her black eye from the previous incident, which she had saved on her phone. Ms K showed Mark's mother the pictures, and said she was keeping them to use against Mark in the future. Mark told his mother that he had not meant to hit Ms K and that the bruise was from his elbow when

he had tried to 'get her off him' during an argument. Ms K was reported not to have contradicted him.

4.2.5 Mark's family all reported within their statements how they had encouraged Mark and Ms K to seek counselling and support, both around their relationship and their alcohol use. In the month leading up to his death Mark had spoken to his parents about his concern regarding Ms K's drinking and they believed he intended to leave her but that he was worried about the financial implications.

4.2.6 In addition to information from family, a number of neighbours provided statements to the police. One reported that they had heard arguments on three occasions, with the last argument one month prior to homicide. They described the arguments as late in evening and always at weekends, and that they believed them to be alcohol fuelled. They described both Mark and Ms K as shouting, and reported that they had seen them both with black eyes. Another neighbour described lots of heated domestic arguments which they suspected were drink fuelled and mostly took place at weekends. They stated that they never felt anyone to be in danger as the arguments consisted solely of slamming doors and raised voices, mostly Ms K's. Another neighbour described having seen Ms K with a black eye and when they asked her about it she told them that her and Mark fought and that she had broken his nose on three occasions. The same neighbour witnessed Mark with a gash on his throat which he reported was caused by Ms K biting him, resulting him in 'having' to punch her to get her to release him. Mark was also witnessed by two other people with injuries/scratches to his face and neck, one of these was a colleague who described seeing Mark with such injuries approximately two weeks prior to his death.

## **5 ANALYSIS OF AGENCY INVOLVEMENT AGAINST THE TERMS OF REFERENCE**

5.1 The involvement of each of the six agencies that completed IMRs is analysed below, with consideration given to the terms of reference set for this review. In examining agency involvement, focus has been upon how the events and circumstances leading up to the death of Mark would have been viewed by individuals involved at the time. While an element of hindsight is difficult to exclude entirely from such a review, and indeed can sometimes assist in identifying lessons learned, every effort has been made to avoid it where possible.

### **5.2 Northumbria Police**

- 5.2.1 Mark had not been identified as a victim of abuse at any point in his contact with Northumbria Police. He was however known to them as a perpetrator of abuse. The IMR for Northumbria police identified that there were five reported domestic incidents involving Mark and two previous partners, dating between 2007 and 2010. These incidents clearly identified him as the perpetrator in all cases, although there was only one incident that was proved to be physical abuse and resulted in prosecution and conviction. In relation to this historical involvement, the review has highlighted that following a verbal argument between Mark and his ex-partner Ms B in February 2010, Probation should have been notified of this call out as Mark was on an Order for an offence of violence against Ms B, and Probation had submitted the relevant documentation to notify the Police of this.
- 5.2.2 It was also identified that during the period of the review there were two domestic abuse incidents recorded between Mark and Ms K, in January and December 2012. In the first of these, although Ms K reported it to be a verbal altercation, Mark was seen to have visible scratches to his face. Despite this Ms K was identified as the victim. The IMR for Northumbria Police outlined that such identification was based on the fact that Mark would not account for the scratches or make a complaint, therefore there was nothing to indicate the scratches had been caused from Ms K. In addition Mark was a known perpetrator of abuse and therefore it was felt by the IMR author that officers acted appropriately in identifying Ms K as the victim and responding in accordance with this.
- 5.2.3 In the second incident it was reported that there was a verbal argument during which both parties hit out at each other. On this occasion Ms K was seen to have bruises, and this, coupled with Mark's history, led officers to arrest him to prevent a breach of the peace.
- 5.2.4 On both of these occasions the IMR author concluded that officers appear to have acted appropriately, and with awareness of domestic abuse issues. With the benefit of hindsight, the death of Mark does prompt further consideration of the incidents in relation to whether Mark had been assaulted by Ms K, or was at risk. This further leads to consideration of whether as a male, and a previous perpetrator of abuse, Mark was less likely to be recognised as a victim. In addressing this the IMR author felt this not to be the case, identifying that all officers are trained to recognise and be aware that males are subject to domestic abuse. The decision to assess Ms K as the victim was based on Mark's previous history, Ms K's injuries on the second occasion, and the lack of anything to indicate that Mark was subject to any other forms of coercive control on the part of Ms K. This led to a professional judgement being made, which identified Ms K as the primary victim based on the information available.
- 5.2.5 At the time when the two incidents occurred, it was the Northumbria Police policy to use the MARAC (Multi-Agency Risk Assessment Conference) model

of risk assessment, which consisted of a twenty point checklist. As Ms K was identified as the victim on both occasions this assessment was completed with her; she was assessed as standard and then medium risk respectively. As a result of these assessments, referral into the MARAC process was not instigated, as she was not identified as a high-risk victim. This would appear appropriate based on the known presenting information.

- 5.2.6 In terms of the risk management actions that followed Ms K was offered a referral to victim support on the first occasion, but declined; on the second occasion she was passed to the neighbourhood policing team for management, as was policy for all medium risk victims. The role of the neighbourhood officer is to: offer support including signposting to other agencies who can assist in safeguarding or supporting the victim; gather intelligence on the offender; discuss safety measures including target hardening measures; reassure the victim; and keep the victim engaged with any criminal proceedings which may be ongoing. As Ms K and Mark were co-habiting, target hardening measures were not appropriate, and as such Ms K was correctly signposted to other agencies and advised regarding personal safety, and safe methods of contacting police and other agencies. On May 2013 Ms K was downgraded to standard risk, as per policy, due to there having been no further domestic incidents.
- 5.2.7 The IMR author for Northumbria Police also identified that while during both incidents of domestic abuse, alcohol was recorded as being a factor, and both parties had previously been banned for driving above the limit, neither had any warning markers for alcohol or drugs. The IMR author concluded that consideration should have been given to placing alcohol warning markers on both records, which could have assisted in identifying patterns of behaviour. It is unlikely however that this would have impacted on any actions taken in terms of assessing or managing the risk.
- 5.2.8 One question raised by the above incidents is whether within risk assessments undertaken by Northumbria Police there needs to be consideration of any evidence that a primary victim may be using defensive or retaliatory violence. As well as indicating risk to the perpetrator, this can also be indicative of increased risk to the victim, as it may escalate violence being used by both parties. There was certainly evidence within the first incident of Mark also having potentially been assaulted, despite him not having reported this.
- 5.2.9 It is unlikely however that any such consideration would significantly have changed outcomes, given that Mark and Ms K's involvement with the police as a couple was limited. While there were indications of domestic abuse there was not sufficient evidence to proceed to prosecution without complaint. There were also no indicators within this contact to suggest that either parties were at a severe or imminent risk, suggestive of the ultimate death of Mark, which

occurred more than a year after his and Ms K's last contact with Northumbria police.

- 5.2.10 At the time of the incidents involving Mark and Ms K, neither of their children was living with them. The IMR author identified that up until the point of her arrest for the murder of Mark it was not known to Northumbria Police that Ms K had a child from a previous relationship. Furthermore no child concerns were raised in relation to Mark's son, as he was no longer living with him. However, given that he may have been having ongoing contact with his son, and there is nothing to suggest that Officers knew otherwise to this, a CCN should have been submitted so this could be considered in relation to any risks related to any ongoing contact with his son.

### Policies, Procedures and Training

- 5.2.11 The IMR author for Northumbria Police identified that all Officers and staff are trained to recognise the risk indicators associated with domestic abuse and are aware of the procedures in respect of dealing with concerns regarding the victim or perpetrator. All of these procedures are available to officers and staff via the force intranet Instructional Information system that is regularly reviewed and updated appropriately. During basic training, all officers receive an input regarding issues arising from a report of domestic abuse. This is reiterated at Area Command training and / or when there is a change in policy or procedure. In 2012 / 2013 as a result of a DHR Northumbria Police identified a need to further develop the understanding around domestic abuse risk assessment among frontline officers and responded by delivering a training package focusing on recognising and recording risk, particularly where a lack of engagement by the victim is a factor. This was completed in March 2013. There is also current ongoing training being rolled out to all staff in relation to coercive control.

### 5.3 National Probation Service

- 5.3.1 The Probation Service in Northumbria has undergone significant changes since the period covered by the review. At the time of Mark's contact, in 2009/10, the organisation was part of the National Probation Service, managed as Northumbria Probation Area, prior to becoming Northumbria Probation Trust in April 2010. On 1<sup>st</sup> June 2014, Northumbria Probation Trust was split into two organisations (National Probation Service and Community Rehabilitation Companies) following the Government's Transforming Rehabilitation initiative. This review pre-dates the organisational split.
- 5.3.2 As regards the Probation Service's contact with Mark, the IMR author identified that the initial risk assessment undertaken included a specific domestic abuse assessment which was used to appropriately identify that Mark was suitable and eligible to attend the Community Domestic Violence Programme. The

focus of supervision when the Order began in 2009 was also appropriate, with the Offender Manager completing the preparatory work for the Community Domestic Violence Programme. However, once Mark reported his intention to work away, initially in Scotland, it became extremely difficult for the offence focused supervision to continue. It also became apparent that Mark was not going to be able to complete the Community Domestic Violence Programme, resulting in the ultimate revocation of the order. Similarly, whilst substance use had been identified as an issue, and as a contributor to the offence, this also remained unaddressed due to Mark's work commitments.

- 5.3.3 Had Mark commenced the CDVP requirement his case would have been discussed at the CDVP Risk Meeting prior to starting the programme, which would have included contributions from the Police and resulted in more informed risk management. In addition, since 5<sup>th</sup> December 2011, a one to one Specified Activity Programme, SOLO, has also been available to the Courts for those domestic abuse perpetrators who are unable to attend a groupwork programme. Had this been available during Mark's Suspended Sentence Order, his Offender Manager could have returned his case to Court and requested that the CDVP requirement be substituted by a SOLO requirement, rather than having the requirement revoked completely. This would have provided another option to engage Mark in offence focused work, however there is no guarantee that his apparent work commitments would not have also prevented him from completing SOLO.
- 5.3.4 As a result of Mark's disclosure in August 2009 that he was moving due to work, the remaining 19 months of the Suspended Sentence Order were spent trying to retain contact with him, and there is no evidence that any meaningful work was completed during this period. The IMR author also identified that there was no continuity of contact, with Mark often been seen by duty officers, and that this resulted in a very superficial level of contact. Furthermore, there was no evidence that he provided any proof of employment and, as a result, his failure to complete any significant offence focused work was based solely on his self-report of employment.
- 5.3.5 Whilst regular risk assessments and supervision plan reviews were undertaken, these also appear to have been based solely on information from self report. There was not felt to be any ongoing risk to the victim of Mark's offence, Ms B, as the relationship had ended and she was believed to be in a new relationship. However, there is no evidence of any contact having been made with Ms B to clarify her perspective; this would usually have been done via the Women's Safety Worker. Furthermore, as already identified, there was an incident reported to the Police in February 2010, however Probation were not informed of this. The day prior to this incident Mark had telephoned the Probation Duty Officer to say that he had returned to work in Scotland that morning, and could not keep his appointment later that day. Had Mark's Offender Manager been aware of the incident at Ms B's home, it would have raised concerns regarding



his attempts to contact his victim as well as doubts about his employment in Scotland.

- 5.3.6 In addition to the above, Mark did not identify his new relationship with Ms K, which information from this review indicates began in early 2010, with them having a joint address from June. Furthermore, no home visit was undertaken to Mark's parents home where he reported to be living; had this occurred it may have resulted in further information coming to light in relation to his new relationship. This lack of information was compounded by their being no evidence in Probation records that Mark was at any stage asked about his social life or who he spent his time with.
- 5.3.7 Finally, when Mark's relationship with Ms K did come to light in discussion of his driving offence in 2011, as no pre-sentence report was requested the IMR author identified that there was no opportunity to discuss this further. Such further discussions would also have included whether or not his new partner had any children, and consideration of whether a referral to Children's Services was needed.
- 5.3.8 While a pre-sentence report was not requested and the Suspended Sentence Supervision Order did expire, Mark was made subject to a Community Order with 200 hours unpaid work. There is no evidence within the IMR of any information being shared with those managing his new Order regarding the concerns around this new relationship, or of any exploration taking place regarding this as part of any risk assessment completed on the new Order.
- 5.3.9 In conclusion, the IMR author identified that there were a number of areas for concern in the management of Mark's case, namely, the lack of evidence regarding employment and over reliance on self report; no continuity of contact with Mark; no home visit; no attempt to enquire further into the Mark's lifestyle to ascertain how he spent his time and with whom; no contact with the Police; and the lack of an investigative and interrogative approach to the management of Mark. The key findings within the Probation IMR were summarised into three areas: communication; evidence gathering and analysis; and relevant and meaningful contact.

#### *Policies, Procedures and Training*

- 5.3.10 The IMR identified that Northumbria Probation Area/Trust has policies, procedures and information sharing protocols in place for dealing with concerns about domestic abuse, and that these were complied with, where required, in this case. The areas of omission that have been identified are in relation to best practice but would not have been required in terms of policy or procedure. Practitioners were identified as having had appropriate levels of training and awareness to enable them to manage domestic abuse/violence cases. However, as can be seen a number of areas for concern have been identified

in relation to the management of this case, which are addressed in the individual agency recommendations for the Probation Service.

5.4 **Newcastle Gateshead Clinical Commissioning Group (CCG)**

5.4.1 The IMR for Newcastle Gateshead CCG identified that while Mark's history of abuse in relation to his contact with the police was unknown to them, he had self-reported in April 2009 that he was awaiting sentencing for common assault. While information within the review has revealed this to be in relation to his ex-partner Ms B, it does not appear that the nature of this assault was revealed to the GP at the time. Had this been the case, records should then have been coded to highlight this.

5.4.2 The IMR noted that Mark's GP practice did have some information in relation to Mark as a perpetrator of abuse through a phone call was made to the out of hours GP service in May 2009. This call spoke of Mark acting in an aggressive manner at his father's house and throwing bricks at windows. This incident would therefore fit the definition of domestic abuse, although was not documented as such within GP records. The author identified that many such incidents involving family members, rather than intimate partners, are not considered as domestic abuse within primary care, due to too narrow a view of what this constitutes. It was also noted however that the doctors from the practice were not directly involved in this incident, and they were only aware of it as a result of the report from the out of hour's service. This would have been one of a number of reports received each day, and the report would have been noted and filed.

5.4.3 The above two areas resulted in Mark's history of domestic abuse remaining undocumented within GP records.

5.4.4 As regards Ms K, there was nothing to indicate that she had been a previous victim or perpetrator of abuse. During the period in which Mark and Ms K were in a relationship, there were no reports to the GP practice of domestic abuse within this. However the IMR author did identify two significant occasions in which there were indicators that were not picked up on and explored further. Namely, Mark's attendance at a GP appointment in February 2013, and Ms K's appointment with a practice nurse in February 2014.

5.4.5 In the first of these, Mark disclosed during a consultation with his GP that he was experiencing stress at work, which was impacting on his home life, where he described being 'angry'. There was no exploration of what he meant by 'angry' at home, and thus this was a missed opportunity to explore whether there was any domestic abuse. The relevance of this is highlighted by the past history of two violent episodes that the review has revealed were documented in the GP records.

- 5.4.6 In relation to Ms K's appointment with a nurse in the GP practice, she presented as depressed and under stress due to financial problems and having to take time off work because of a broken boiler. The nurse undertook a comprehensive assessment including considering the risk of self-harm. Ms K described her family as a protective factor, and the nurse understood this to include her partner. It should be noted that Ms K made no disclosure of domestic abuse during this consultation. It is understandable then that in the presence of a clear precipitating factor for Ms K's distress, she was not asked directly about domestic abuse. However, selective enquiry is recommended whenever a woman presents with mental health issues. During interview with the IMR author, the nurse confirmed that although she has a structured approach to the assessment of mental health problems, including consideration of alcohol use, substance use and self-harm, she does not ask about domestic abuse as a matter of routine. Ms K's disclosure of an extensive history of abuse to this review, and the proximity of the above appointment to the death of Mark, highlights the importance of undertaking domestic abuse enquiry, as this would have provided an opportunity for disclosure of any concerns.
- 5.4.7 In considering the presence of substance use and mental health issues in the case of both Mark and Ms K, the IMR author also explored the way in which this was addressed by GPs. The review highlighted that Mark had a number of consultations over several years regarding depression, excessive alcohol consumption, and cocaine use. On each occasion an appropriate assessment was undertaken. He did self-refer to Plummer Court in April 2009 and underwent an assessment. However, following this he does not appear to have engaged in treatment with Lifeline. He presented again with stress related issues and alcohol problems in February and November 2013. On both occasions he was given advice on self-referral routes but does not appear to have followed this up. In March 2013 it is documented that he was taking double the recommended dose of a supplement and body building medications. The GP understood this to be protein supplements. On two occasions during 2013 Mark failed to arrange blood tests as requested to do. Practice A has a recall system to ensure follow up of particularly vulnerable patients to ensure that blood results for example are taken. This is an example of good practice. Although Mark had a degree of vulnerability due to his mental health problems and substance use, this was not of such an extent to deal with him as part of this system.
- 5.4.8 The IMR author identified that 'self-referral is the recommended route in many mental health services on the basis that it indicates client motivation. However, there is a danger that non-engagement is not followed up. It appears that (Mark) had variable motivation to address his alcohol and substance use issues and never established an effective therapeutic partnership with his GP or other professional to do this. Looking at each consultation when he presented to his GP in isolation his management was appropriate. However, the fact that there

was a pattern of presentation, self-referral and lack of ongoing engagement was not appreciated so that alternative strategies could be considered.'

- 5.4.9 Ms K also had a significant alcohol problem between at least 2007 and 2010. There is an indication in her GP records that she was referred to ESCAPE but no information recorded to confirm that she was ever seen, although as part of this review it has been confirmed that she did attend. The IMR author identified that Ms K does not subsequently appear to admit to an ongoing problem to her GP, and thus this does not appear to have been explored to any significant extent in 2011 and 2013. This is despite the fact she was found to have large red blood cells and had a history of disclosed alcohol use. Finally, when the practice nurse saw Ms K in February 2014 she was noted not to be alcohol dependent. Her past history of alcohol problems was listed on her summary, but the nurse did not explore this in any detail.
- 5.4.10 In relation to the children of Mark and Ms K, after 2007 no mention is made in Mark's records of his child. There was no consideration of any risks to his child in February 2013 when he disclosed that he was angry at home, nor did the GP know if his partner at the time had any children. This links to similar issues identified within the analysis of contact by Northumbria Police. Firstly, that where there is concerns regarding behaviour at home, whether or not it is labeled as domestic abuse or violence, wider consideration is not always given to any risks to children outside of that home with whom the individual may have contact within a familial setting. Secondly it appears that agencies working with individuals do not always have information regarding children and who constitutes their family.

#### Policies, Procedures and Training

- 5.4.11 In relation to policies and training around domestic abuse, both GP practices involved in this review had policies for child and adult safeguarding which cover some aspects of domestic abuse. Since the homicide, Practice A has adopted the exemplar practice policy on Domestic Violence and Abuse that was produced by the GP Lead for Adult Safeguarding following an earlier review. This policy was also brought to the attention of Practice B, who had no such policy in place.
- 5.4.12 The review also identified that while the GP referred to within the review had had training in domestic abuse, the practice nurse had not. The IMR identified that the need for training in this area was highlighted by recent NICE Guidance and by other local Domestic Homicide Reviews. Such training is not currently mandatory but the Newcastle Gateshead CCG has published a Safeguarding Adults Training Plan for Primary Health Care Teams. This recommends that all

clinicians should undertake Domestic Violence and Abuse training every three years.

5.5 **Newcastle upon Tyne Hospitals NHS Foundation Trust (NUTH)**

5.5.1 Within their IMR, NUTH identified that they had no relevant contact with Mark and only one key contact with Ms K that they felt was relevant in relation to this review. This was her attendance at hospital in March 2013 when she presented with bruising that was not as a result of injury but of a medical problem. Ms K reported that she was upset, as she had had an argument with her partner. The IMR author noted that the nurse was sensitive to this and deferred taking the routine observations due to the patient's upset, and also documented what Ms K had told her.

5.5.2 With hindsight however it can be recognised that the nurse could perhaps have enquired further about the argument, which would have opened up the opportunity for Ms K to disclose any concerns about domestic abuse; particularly in light of the fact that her level of distress was such that routine observations were deferred and she had a history of alcohol misuse. However, as medically her bruising was known not to be linked to external injury, and no previous concerns recorded regarding abuse, there were no obvious indicators that would have prompted the use of selective enquiry. While the nurse's response appears to be appropriate in the circumstances, as in the case of the contact with the GP this highlights the potential benefits of routine enquiry in providing opportunities for disclosure.

5.5.3 Such benefits are further demonstrated through the disclosure made by Ms K to this review, that at the incident in September 2012 her finger had in fact been broken by Mark and not through trapping it in a safe door. On her attendance at hospital her injury was seen as consistent with the explanation given, and therefore did not give cause for concern or prompt selective enquiry around domestic abuse. While the response was therefore appropriate and no omission occurred, such an incident highlights that had routine enquiry been used, this is one occasion when disclosure may have occurred.

**Policies, Procedures and Training**

5.5.4 As regards policies and training, the Trust have undertaken significant steps in relation to addressing domestic abuse. A comprehensive policy for Safeguarding Adults including domestic abuse, which contains guidelines on what actions staff are expected to take. It is the responsibility of all staff to be familiar with the policies of the Trust, to know where they can be accessed, and to follow those policies if and when required.

5.5.5 All Newcastle Hospitals trust staff must undertake mandatory training on Safeguarding Adults and Children at Level 1 and Level 2 every 3 years, as relevant to their clinical role. Level 1 training is for all staff both clinical and non-clinical. It includes basic awareness of safeguarding; signs and indicators, recognition of abuse, categories of abuse, risk factors and what to do if staff have a concern. Level 2 training is for all staff that hold a professional qualification. There is an expectation that staff will have completed Level 1 prior to attendance. Domestic abuse is incorporated into both Level 1 and Level 2 training packages. Uptake of training is monitored by the Trust and managers to ensure compliance and is recorded. Additional training on domestic abuse is available from Safe Newcastle via the Domestic Violence and Abuse Multi Agency Training Programme. Services and departments have members of staff who have either been nominated, or volunteered, to attain an increased level of knowledge pertaining to domestic abuse. These staff will access additional training, disseminate information back to their service, and act as a resource for the service. Access to the training is not restricted to nominated individuals however and can be requested by other individual staff members who demonstrate they have an interest through both annual appraisals and the Trust's study leave application process.

5.6 **Northumberland Tyne and Wear NHS Foundation Trust (NTW)**

5.6.1 Mark had one contact with NTW in 2009, which from the information available to this review would appear to be prior to the commencement of his relationship with Ms K, as well as being outside the direct terms of reference for this review. However it was felt relevant to include within the review, as it provides background context, as well as being one of the only contacts Mark is known to have had with support services in relation to his substance use.

5.6.2 The IMR for NTW identified that Mark's self referral was made to address his substance use, as this had an impact on his mood and made him violent and aggressive. During the assessment Mark discussed the breakdown of his most recent relationship with the nurse, blaming this on his use of cocaine; no domestic abuse was reported at this time, or any indicators identified. The FACE risk assessment (NTW's risk assessment document), which was completed with Mark, did not identify any domestic abuse, as either a victim or perpetrator. It was recognised by the IMR author however that while the FACE tool would identify all risks, including domestic abuse, this would depend on specific questioning and an honest response. As Mark did not directly identify any issues regarding domestic abuse, this does not appear to have been explored with him further.

5.6.3 Mark did however comment that his level of aggression was increasing, and the IMR author could not see within the records any discussion or further exploration of this comment. Accordingly, for the purpose of this DHR, the IMR author interviewed the assessing nurse, and following review of the records the

nurse reported that he had vague recollection of the assessment. He informed the author that this was an evening assessment, which are offered to clients who appear as non complex and low risk. The nurse stated that he 'warmed' to Mark and had no concerns during the assessment. There was nothing discussed that alerted the nurse to explore domestic abuse with Mark. The comment Mark made about his friends describing him as becoming more violent and argumentative was however explored, and Mark stated this was when he was out with friends and under the influence of alcohol and cocaine, again giving no indicators to prompt further exploration of domestic abuse.

- 5.6.4 The victim was only seen once for assessment, he presented well, and described 'binge' drug and alcohol use. The outcome of the assessment appeared to focus on his substance use, and as such he was signposted to more appropriate services to address this. No mental health issues were identified, other than low mood and sleep disturbance, which could have been directly linked to illicit substance use.
- 5.6.5 During the assessment, children were discussed and it was documented that Mark had a son from a previous relationship, who was reported to be approximately three years old. Mark stated he could not recall his son's date of birth, had no contact with the child, and that his relationship ended while his ex-girlfriend was pregnant. The IMR author could find no explanation or exploration as to why this relationship ended and why he had no contact with his son. However, given this lack of contact, no referrals in relation to the child were felt necessary.
- 5.6.6 Following the assessment of Mark, as in the case of all patients undergoing assessment within addictions services, the assessing nurse presented the case to a multi disciplinary management panel that confirmed the future plan for care and treatment. Following confirmation of this plan a letter is sent to the referrer, the patient, the GP and any other relevant service involved with the individual, as was the case with Mark.
- 5.6.7 The IMR author identified that there were no factors present to indicate the existence of any concerns around domestic abuse, and the response of the practitioner with Mark would appear appropriate based on the presenting concerns. However as in the case of GP contact, and Ms K's contact with hospital staff, there are areas that could have been explored further and perhaps prompted direct questioning around domestic abuse. These include the breakdown of his previous relationship, the lack of contact with his son, his reports of aggressive behaviour, and the presence of substance use and low mood. However, any further exploration of this would have still been reliant on Mark disclosing issues in relation to domestic abuse, without which there is little further action that could have been taken.

5.6.8 At the time of the assessment of Mark, NTW did not have a policy on Domestic Abuse. However the Safeguarding and Public Protection Team were subsequently established to support staff with any concerns. Since this time a Domestic Violence and Abuse policy has been put in place, and staff have had training and briefing sessions regarding both the policy and MARAC procedures. The Trust have a dedicated MARAC Champion and senior MARAC practitioners who support staff with all domestic abuse concerns providing advice, supervision and support when necessary. In interview, the practitioner who saw Mark stated that at the time (2009) he had basic awareness of domestic abuse, but feels more informed and competent now that the Trust has a policy in place, dedicated staff, and regular training.

5.7 **Northumberland County Council Children’s Services**

5.7.1 Within the terms of reference of this report dating from 2010, Northumberland County Council Children’s Services had only two contacts regarding Ms K’s daughter Donna. However prior to this the IMR noted that there had been two previous contacts with Children’s Services in December 2007, both which appear to have been dealt with appropriately given that Donna was felt to be in the safe care of her father.

5.7.2 In April 2010, when Mr C expressed his concerns that Ms K was experiencing problems with alcohol use, and had been violent towards him, advice and information was provided around seeking legal advice in relation to contact. The ‘Provision of Information and Advice’, which was completed is a short intervention, with the case being opened and closed within 24 hours. Ms K was living with her parents at this time and as Donna was in the full time care of Mr C, and had been living apart from Ms K for some time, there were no concerns for her safety and therefore there did not appear to be any further action warranted to safeguard her. The IMR author identified that in all cases where either separated parent raise issues about contact difficulties, where there are no concerns about the safety of a child, parents are signposted to seek legal advice.

5.7.3 The IMR noted however that at this point, involvement focused upon what the father was reporting about the situation, as he had care of Donna and appeared to have taken steps to ensure her safety. The IMR author identified that it is likely that if this situation arose now, with further understanding and practice in dealing with concerns about alcohol use and violence, that there would have been direct contact made with Ms K to assess her account of the circumstances leading to the reports of her alcohol and aggression, taking into consideration the potential for retaliatory violence. The current practice would now involve the Social Worker making direct contact with Ms K and exploring her view of the reasons for her alcohol use and aggression towards Mr C, and potentially also confirming that issues around future contact would be addressed and both parents aware of legal options. While the level of intervention was considered



appropriate at the time, as the nature of the referral was focused upon a dispute over contact arrangements for the child, contact would now routinely be made with Ms K to assess the information given by Mr C. Had this occurred, this would have ensured a fuller assessment of the reasons for reports of alcohol use and aggressive behaviour. Furthermore, depending upon the assessed information, this may have led to a more detailed assessment of the circumstances of both parents in caring for Donna. It is now standard practice that if these type of concerns are raised, there is contact with the other parent to ensure an assessment is balanced with the accounts and views of both parents.

- 5.7.4 Following the above, Ms K does not appear to have been significantly involved in her child's life for several years, and from April 2010 she had moved out of the local area. Children's Services did not receive any further concerns until they were notified of the homicide in Newcastle. The second contact therefore within the timescale of the DHR was in March 2014, as a result of the Police notification of Ms K being arrested following the death of Mark. Mr C stated his daughter was safe in his care and had no contact with mother for the past few years. In light of this it was not felt that any further involvement from Children's Services was warranted.

#### Policies, Procedures and Training

- 5.7.5 The IMR author reported that Children's Services' staff are knowledgeable and skilled in working with domestic abuse issues, including an awareness that both males and females can be both perpetrators and victims of domestic abuse. However, it was recognised that there has been an increasing recognition of the complex issues involved around domestic violence since 2010 and a need to ensure that there is a full and detailed view about any allegations of violence and the factors involved. The author considered that Social Workers are fully aware of the need to assess and consider support if required and knowledgeable about specialist resources available. Social Workers are also required to attend mandatory training around the impact of domestic abuse upon children, with specialist training also available, including training around the use of MARAC. They were felt to have a clear understanding of the tools to support assessment around domestic abuse.
- 5.7.6 In addition, since August 2015, the use of a Provision of Information and Advice (PIA) has now ended. There is now increased use of Early Help Assessments, which more routinely involve direct contact with all appropriate family members and if there are concerns about domestic violence which meet the threshold for allocation of a child care Social Worker, a Children and Family Assessment will be completed. Both assessments will include careful consideration of any domestic abuse issues.

- 5.8 **ESCAPE Family Support**

- 5.8.1 ESCAPE had two periods of contact with Ms K from May to August 2009, and May 2010 to March 2011. During such contact, keyworker one to one support was the only intervention offered as part of Ms K's care plan, and both discharges from treatment were requested by Ms K. At these discharges it was recorded that Ms K was 'alcohol free'.
- 5.8.2 The IMR author identified that there was no information within the case file to suggest that Ms K was a perpetrator or victim of domestic abuse. Records do however indicate that Ms K felt emotionally 'controlled' by her mother and husband (prior to her relationship with Mark), and work was undertaken with her by the allocated keyworker regarding being assertive.
- 5.8.3 As regards her relationship with Mark, a case recording of a telephone conversation on 29/12/10 refers to Ms K living with a male in Newcastle, but there is no information recorded regarding the name of the male or the address. The recording does state that the keyworker asked Ms K if she was safe or in danger and no concerns were indicated.
- 5.8.4 The case file also indicated that at the time of ESCAPE's involvement in 2010, Ms K's contact with her daughter was restricted due to her alcohol misuse and there were ongoing issues regarding contact arrangements. It was noted that Children's Social Care at Ashington had been involved with the case.
- 5.8.5 The IMR author indicated that a paper based case recording system was in place at ESCAPE at the time of their involvement with the Ms K and some handwriting within the file was difficult to read. An electronic case management system was established in 2013, which it was felt significantly improved the case management system. In addition some case recordings on the file were not in sufficient detail. Case Recording Training was previously identified as a training gap for some staff, and all staff took part in Case Recording Training in 2012 by ICIS Training.
- 5.8.6 In addition to the above the current assessment documentation clearly considers domestic abuse within the risk assessment, and all volunteers and staff have updated training regarding domestic abuse.

5.9 **Other Issues Considered**

- 5.9.1 As part of the review process consideration was also given to issues of equality in line with the Equality Act 2010. In the case of Mark and Ms K, there were no specific issues identified in relation to race, religion, age, sexual orientation, gender reassignment or disability that were seen to be relevant to the review process. As regards gender, the issue of Mark as a male victim of domestic abuse has been considered throughout the review process.

- 5.9.2 Neither Mark nor Ms K was identified as a high risk victim and they were not subject to MARAC or Safeguarding procedures. There was nothing known to agencies at the time to suggest these procedures should have been instigated.

## **6 LESSONS LEARNED AND CONCLUSIONS**

- 6.1 It has emerged throughout this review that Mark had not been identified by any agencies with whom he was involved, as a victim, or indeed potential victim, of abuse. Similarly, Ms K was not previously identified as a perpetrator in relation to Mark. Both Mark and Ms K's contact with agencies over the years was intermittent and there was no prolonged engagement from either with any services, with the exception of Mark's probation supervision from April 2009 to April 2011, which in itself was limited. Contact with agencies was also minimal in the year preceding Mark's death, which is of particular note given that information from family, neighbours and colleagues indicates that during this period there was increasing abuse within the relationship, with Mark notably being seen on a number of occasions with injuries that he did not report to agencies.
- 6.2 Despite their lack of prolonged engagement with any one service, when Mark and Ms K's contact with different agencies is viewed as a whole, a picture develops of a couple who both had significant difficulties. Mark was known to have a history of violence in two previous relationships and police were called on two occasions in which he was believed to have been violent toward Ms K, although no charges were pursued. Since 2006 he had also identified, at various appointments, difficulties around depression, low mood, and cocaine and alcohol use; although he did not go on to engage significantly with any services in addressing these. There was also evidence of both self-report, and reports from other sources, around his 'aggressive' behaviour, which largely remained unaddressed. The one most significant opportunity to address both his abusive behaviour and his substance use came with the imposition of a Suspended Sentence Supervision Order in 2009. His engagement with this was however extremely limited, and very little focused work was undertaken.
- 6.3 Ms K has also emerged as an individual experiencing mental health difficulties and ongoing alcohol use problems; other than two periods of contact with ESCAPE, she did not engage with any other services to address these. She was also known by the police as a victim of Mark's abuse, had made disclosures to her employer, family and neighbours, and made further disclosures regarding this within the review process. Her engagement with agencies however appears to have been relatively superficial and she was not therefore engaged in addressing her experience as a victim. In addition, there was a historical report from her ex-husband of her being violent towards him on two occasions, as well as towards her own family, although this information was reported solely to Children's Services and was unknown to other agencies.

6.4 As both Mark and Ms K had intermittent and relatively superficial contact with most agencies, it is subsequently only with hindsight that this picture emerges of an abusive relationship in which the ‘toxic trio’ of domestic abuse, substance use and mental health issues were present. As a result of this, a number of lessons have been identified that may help to improve responses of agencies and seek to aid the identification and addressing of these wider issues at an earlier stage.

6.5 **Lack of further exploration of presenting issues and the ‘toxic trio’**

6.5.1 There were a number of occasions during Mark and Ms K’s contact with agencies where further exploration could have been undertaken to go beyond presenting issues or self-report. These included:

- Mark’s assessment appointment with Plummer Court in 2009 in which he spoke of the breakdown of his previous relationship, the lack of contact with his son, his aggressive behaviour, and the presence of substance use and low mood.
- Mark’s supervision by the Probation Service from April 2009 to April 2011, in which no exploration took place regarding his social circumstances, and his report of both his employment and home situation was taken on self-report with no verification being sought.
- Mark’s contact with his GP practice in February 2013 when he spoke of stress and being ‘angry’ at home.
- Ms K’s presentation at a hospital assessment in March 2013 when she presented as distressed and upset due to an argument with her partner.
- Ms K’s appointment with a practice nurse in February 2014 when she spoke of stress and depression.

6.5.2 Within the above there was little evidence of any in depth exploration of presenting issues, or consideration of underlying causes or the interplay between various factors. This is particularly relevant given the presence of the ‘toxic trio’ of mental health, substance misuse and domestic abuse. Previous DHRs nationally have highlighted that focusing on one of these areas may detract from recognition of concerns relation to domestic abuse. While there is no evidence that any clear indicators of abuse were missed due to a focus on other areas, what can be seen is that the presence of mental health and substance use issues did not act as a ‘trigger’ for consideration and exploration around domestic abuse. NICE<sup>1</sup> public health guidance, 2014: ‘Domestic violence and abuse: how health services, social care and the organisations they work with can respond effectively’ recommends that agencies ‘ensure trained staff in antenatal, postnatal, reproductive care, sexual health, alcohol or drug use, mental health, children’s and vulnerable adults’ services ask service users whether they have experienced domestic abuse. This should be

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<sup>1</sup> National Institute for Health and Care Excellence

a routine part of good clinical practice, even where there are no indicators of such violence and abuse’.

- 6.5.3 While the above focuses on the undertaking of routine enquiry with potential victims in specific settings, what this review has also highlighted is the need to explore concerns expressed by perpetrators around their own behaviour, as in the case of Mark’s disclosures. Mark’s expression of concern regarding his own aggressive or paranoid behaviour, or the breakdown of his relationship, while not specifically identifying domestic abuse, may have been attempts to prompt further questioning. Such exploration could potentially have led to disclosures relating to his own behaviour as a perpetrator, or concerns he may have had regarding his own victimisation.
- 6.5.4 In addition the need for a potentially wider use of routine enquiry around domestic abuse (that which takes places routinely without the need for indicators to be present), or a broader criteria for selective enquiry (that triggered by indicators), has also been demonstrated in relation to Ms K’s contact with services.

**Recommendation 1: Newcastle Gateshead CCG, NUTH, National Probation Service – North East Region, Northumbria CRC, Northumbria Police, NTW and Northumberland Children’s Services to ensure that key learning from this review around further exploration of presenting issues and the need to gather full social histories, is disseminated to relevant staff and considered in any reviews/audits of training, policy, procedure and practice.**

**Recommendation 2: Newcastle Gateshead CCG, NUTH, National Probation Service – North East Region, Northumbria CRC, Northumbria Police and NTW to review their policy, procedure and guidelines for selective and/or routine enquiry in relation to domestic abuse, and ensure that routine enquiry is undertaken where possible. Where selective enquiry is used policy, procedures and guidelines should ensure that it would be triggered by the following:**

- **Presence of substance misuse and/or mental health concerns.**
- **Expressed concerns regarding relationship difficulties.**
- **Expressed concerns regarding management of own behaviour or ‘anger’ issues.**

- 6.5.5 In addition to the above the National Probation Service identified a specific recommendation for their agency to ensure relevant and meaningful contact with offenders in order to manage the risk posed by Domestic Violence. It was also further highlighted within a Panel meeting by the NPS representative that such meaningful contact should include such contact as takes place with duty officers.

6.6 **Silo working and a lack of information sharing or follow up**

- 6.6.1 What emerges clearly from the review is that while Mark and Ms K's contact with each individual agency may have been limited, when information was joined together a concerning picture emerges of a potentially volatile situation between two individuals both with extensive histories of substance use, mental health concerns, and a background of violence and abuse. Unfortunately, none of the agencies involved were aware of the full extent of this broader picture, and while such a view is aided significantly with hindsight and the nature of a review process, it has been identified that there were a number of occasions in which information could have been shared or sought that may have widened the perspectives of some of the agencies involved.
- 6.6.2 This is particularly relevant in the case of the Probation Service who were working specifically with Mark to address his abusive behaviour, yet did not seek information from his victim Ms B. In addition, Northumbria Police failed to inform them of a further police call out relating to the victim of the offence for which he was being supervised. While this pre-dates Mark's relationship with Ms K, such information may have changed the nature of his supervision in addressing his use of abusive behaviour at this earlier stage. In addition, no attempts were made to verify Mark's report of employment, and when Mark disclosed his new relationship three weeks prior to the expiry of his Suspended Sentence Supervision Order, there was not felt to be time to obtain information regarding his new relationship. However he was made subject to a further Order of Unpaid Work and such issues could have been shared and then picked up by those responsible for the management of the new Order.
- 6.6.3 In the case of the GP this issue can be seen to be most present in the addressing of Mark's substance use and mental health. It has been identified that while self-referral is the recommended route in relation to addressing mental health or substance use, this can lead to lack of follow up. Dating from 2006, Mark often presented with issues relating to substance use of mental health difficulties and was offered referral information. However, there appears to be little review of any subsequent engagement, or lack of. As a result, each time he presented the same pattern ensued and each incident was dealt with in isolation with little consideration of whether a different approach was necessary, or liaison with other services needed. In addition when Mark presented in 2013 expressing concerns around his anger at home, there is no evidence of this having been considered against Mark's self report to his GP in 2009 that he was awaiting sentencing for common assault, or information previously provided indicating Mark to be a perpetrator of abuse in relation to his parents.
- 6.6.4 Similarly in the case of Ms K, while between 2007 and 2010 she reported a significant alcohol problem, her presentation at later appointments, in which she did not raise this as an ongoing issue, does not seem to have been

considered against her history and her presenting medical concerns around large red blood cells.

- 6.6.5 Within the above, there can be two issues identified, an element of ‘silo’ working both in the lack of information sharing between agencies, but also agencies working with little reference or consideration to past issues identified in their own contact with individuals.

**Recommendation 3: Newcastle Gateshead CCG to highlight with GP practices the need to ensure that key issues linked to substance use, mental health, or reports of aggressive or abusive behaviour, are highlighted on GP records so that past information can be reviewed and included in consideration of presenting issues.**

**Recommendation 4: Northumbria Police to ensure processes are in place to alert frontline staff of the need to inform Offender Managers within the National Probation Service and Northumbria CRC of any call outs/concerns in relation to individuals who are being supervised for domestic violence offences. To identify actions to address any gaps found in processes.**

- 6.6.6 In addition to the above specific single agency recommendations were identified by the National Probation Service to improve communication between Police and Probation Services in managing the risk posed by Domestic Violence Perpetrators; and to improve evidence gathering and analysis by NPS staff in managing the risk posed by Domestic Violence Perpetrators.

6.7 **‘Think Family’**

- 6.7.1 As can be seen Children’s Service had limited involvement in relation to either Mark’s son or Ms K’s daughter and within this, concerns appear to have been raised and acted upon appropriately when there were direct risks identified to them. The lack of any sustained intervention was based on the fact that in both cases the children were in the full time care of their other parent.

- 6.7.2 However, as in relation to previous issues identified around failures to explore presenting information in any depth, it has emerged within this review that agencies often had a lack of information regarding the children. In addition there was occasions when the issue of indirect risk to the children was not fully considered.

- 6.7.3 In the case of Northumbria Police, when responding to incidents of abuse between Mark and Ms K it was not known that Ms K had a daughter, and no CCN was submitted in relation to Mark’s son, as he was no longer living with him. However, given that it was unknown as to whether he was having contact

with his son, this should have been considered. In the case of the Probation Service, who supervised Mark for two years, it is not clear as to whether they were aware of Mark's son from a previous relationship. Furthermore in relation to the disclosure of his new relationship, as already outlined, no steps were taken to identify any children within this. Similarly in the case of Mark's GP there was no mention made in Mark's records of his child, and no consideration of any risks in February 2013 when he disclosed that he was angry at home, as the GP did not know if his partner at the time had any children.

**Recommendation 5: Newcastle Gateshead CCG, NUTH, National Probation Service – North East Region, Northumbria CRC, Northumbria Police and NTW to ensure that full information regarding family structure is sought, where appropriate, at initial contact, and reviewed when any concerns around abuse are identified. Any presenting concerns/risks should be considered in relation to any identifiable children or adults with whom individuals may be having contact, and sharing of information with other agencies considered.**

6.8 **Understanding the dynamics of the domestic abuse and the issue of gender**

6.8.1 Within this review possibly one of the most difficult areas to consider was the dynamics of the abuse that led to the tragic death of Mark. Most notably Mark had not previously been identified as a potential victim at the hands of Ms K. He was however identified as a perpetrator of abuse on five occasions in two previous relationships.

6.8.2 Very little is known from this review regarding Ms K's previous relationship, although there was a report to Children's Services, from her ex-husband, of her being violent and aggressive towards him on two occasions (2008 and 2010), as well as abusive towards her parents. However within interview Ms K also intimated that her husband had been emotionally controlling and abusive, something she had also previously raised during her contact with ESCAPE.

6.8.3 As regards the relationship between Mark and Ms K, there were two incidents of reported abuse, in both of which Mark was identified as the primary perpetrator. As previously discussed this would appear to have been a reasonable identification based on the presenting information. It should be noted though that there was reference within one Police incident to both parties having 'hit out' at each other, although Ms K solely presented with bruises, and within another incident to Mark having scratches to his face. As part of this review Ms K also spoke of being subject to a pattern of controlling and abusive behaviour, including high levels of physical violence, which she alleges she started to defend herself against through the use of physical violence. She identified a high level of fear and spoke of one occasion in which Mark had held a gun to her head. It was corroborated that a gun was found in the house following the homicide. The presence of a gun in the home is indicative of a high level of risk in a domestic abuse situation; it should be recognised however



that this was not known until after the homicide.

- 6.8.4 It is of course, impossible to know for sure, the full extent or nature of the abuse between Mark and Ms K, although the information available to agencies, would, up until the time of the offence, have suggested Mark to be the primary perpetrator. In addition Ms K's account of her experience for the purpose of this review, was consistent with the limited information she had provided to services previously, and her presentation was congruous with that of someone who had experienced significant abuse.
- 6.8.5 However, during the gap of one year in which no incidents were reported prior to Mark's death, information available from Mark's family and friends, and Ms K's manager, suggests that there was a deterioration in the relationship during this time and that the physical violence escalated, with Mark having been seen on a number of occasions with injuries including a stab mark to his leg, scratches to his face, bite marks to his thumb, and a self reported broken nose. This could be both suggestive of an escalation in Ms K's violence towards Mark, or indeed increasing attempts to defend herself against the abuse she reported to have been suffering.
- 6.8.6 As regards the actions of agencies, there has been no information shared to suggest that any significant indicators of Mark as a victim were missed, other than the opportunity to further consider and explore his presentation with scratches to his face during an incident to which police were called.
- 6.8.7 In relation to Ms K she herself identified that despite being aware of where she could seek help, she actively sought to 'cover up' the abuse, feeling ashamed at what she was experiencing and not ready to seek help. In addition she spoke of her fear at the consequences should she try and leave Mark. She was adamant however that there was nothing further anyone else could have done at this stage, as she was not yet ready to engage with services. It is unlikely therefore that had further exploration taken place with Ms K on the occasions identified previously, such as her presentation at hospitals or at the GP, this would have led to disclosure. She went on however to identify one area she felt may have encouraged her to take steps earlier, and this was had she been made aware of the extent of Mark's abuse towards previous partners. This issue is addressed with Northumbria Police's IMR in discussion of the Domestic Violence Disclosure Scheme (commonly known as Clare's Law) which was launched nationally on 01/04/14. This introduces a framework to enable police to disclose information to a member of the public about the previous violent offending history of a new, existing or previous partner with a view to safeguarding them from violent offending / risk of harm. While publicity had been given to the launch of the scheme, Northumbria Police identified a single agency recommendation to consider the need for a publicity campaign highlighting the Domestic Violence Disclosure Scheme.
- 6.8.8 It should be noted that Ms K remained adamant that the only one who could

have stopped the tragic events that occurred was herself, and she identified that she should have actively sought help sooner.

6.8.9 What therefore can we learn from all the above? With the benefit of information obtained from family and friends it has become clear that within the relationship of Mark and Ms K there was an escalating risk that remained hidden from organisations. Indicators of such risk included Ms K's references to her employer of financial issues, alcohol use, both parties having presented with injuries and the presence of a gun within the home. Even if further information had been known however there is the potential that the extent of the risk to Mark would not have been recognised. No clear indicators emerged from the review to suggest that this was due to Mark's gender, although the influence of this cannot be completely ruled out. Primarily however it was identified that due to Mark's history as a perpetrator, and Ms K's contact with agencies primarily as a victim, this would potentially lead to any assessments of the situation being based on this, as appears to have been the case in their contact with Northumbria Police.

6.8.10 What this highlights, is that risk assessments or processes that are used by agencies are based on identifying a primary victim, which can lead to difficulties in cases of violence by both parties, or in relation to potential defensive, retaliatory or other violence by a primary victim. In this latter case this can then lead to a failure to recognise the resulting risk posed to both parties in terms of the use of escalating and possibly fatal violence. While there was limited information that would have informed any risk assessment around this in relation to Ms K, it is however important that the issues raised within this review are considered more widely in relation to possible future cases with similarities. Within research by Marianne Hester<sup>2</sup> it was identified that female perpetrators of abuse were less likely to use physical violence, threats or harassment, although much more likely to use a weapon. It was also noted that this was often in order to stop further violence from partners. Other findings from the research also identified that 'women who use violence in self-defence to escape or protect themselves were, as in many other studies, a prevalent group'.

**Recommendation 6: Newcastle Gateshead CCG, NUTH, National Probation Service – North East Region, Northumbria CRC, Northumbria Police, NTW and Northumberland Children's Services to ensure that key learning from this review around the dynamics of primary and secondary perpetrators, and the potential risk around retaliatory or defensive violence to all parties, is disseminated to all relevant staff and considered in any reviews/audits of training, policy, procedure and practice.**

6.8.11 Finally in relation to the above, it is recognised that many agencies utilise the

<sup>2</sup> Hester, M (2009): 'Who Does What to Whom? Gender and Domestic Violence Perpetrators'; and Hester (2012): 'Portrayal of Women as Intimate Partner Domestic Violence Perpetrators'.

CAADA DASH risk assessment and are part of the MARAC (Multi Agency Risk Assessment) process. The DASH risk assessment does not prompt any direct consideration of retaliatory or defensive violence, although it is recognised that assessments could be undertaken in relation to both parties as victims. Given the familiarity of many agencies with the MARAC process, and the associated risk assessment, the Panel felt it may be useful if the learning from this review could be used to inform any developments around the use of this risk assessment. In considering how to achieve this it was identified that there is ongoing research being undertaken by the College of Policing, in collaboration with the What Works Centre for Crime Reduction and Cardiff University, into risk-led responses to domestic abuse and the use of the DASH risk model. The project is a national piece of work arising from Recommendation 6 of the 2014 HMIC inspection ‘Everyone’s business: Improving the police response to domestic abuse.’

**Recommendation 7 (national): Learning from this review to be shared with both Safelives (previously CAADA - Coordinated Action Against Domestic Abuse) and the ongoing review being undertaken by the College of Policing, to request that consideration be given to issues of primary and secondary perpetrators, retaliatory and defensive violence, and how this may be included in developments around risk assessments and processes.**

**6.9 Information held by family, friends, colleagues and the broader community.**

6.9.1 As has been highlighted, in the months leading to the tragic death of Mark, family, neighbours, and colleagues appear to have held more information than agencies around the nature of the relationship between Mark and Ms K, and the abuse within this. While there is evidence of support and advice being offered, and both Mark and Ms K having been advised to seek help, the exact nature of this is unknown. In addition, there is no evidence of the police having been called, despite both Mark and Ms K having been seen with injuries and there having been continued ‘arguments’ heard by neighbours. How family, friends and neighbours can be made aware of issues relating to domestic abuse, and the avenues open to them in addressing this and supporting those close to them, is an issue highlighted by previous Domestic Homicide Reviews within the local area. Within Newcastle, one such review resulted in a recommendation that Safe Newcastle agree an approach with partnership agencies to increasing community awareness about domestic abuse so that family and friends of victims know where to access appropriate advice and support. In response to this, Safe Newcastle are working in partnership with Northumbria Police to deliver a Christmas domestic abuse campaign focusing on family and friends, which is to be delivered from November 2015 to January 2016. In addition, an article is to be featured in Newcastle City Council’s City Life Winter edition to raise awareness of what friends and family can do in cases of domestic abuse.

- 6.9.2 Finally, it has also been identified that although Ms K's employers could not be directly involved in this review, information from Ms K's manager at the time highlighted the potential absence of policies and procedures in place to address domestic abuse issues or to assist in addressing such issues appropriately in relation to disciplinary matters. She also identified a lack of support as a manager dealing with this. It should be noted that as the company in question is no longer responsible for the service for whom Ms K was working, no contact could be made with relevant representatives to allow them to respond. However while they no longer manage that particular service, Ms K's previous employer are a large national organisation and it was agreed by the Panel that the relevant outcomes of this review should be shared in order that they consider them in relation to any changes that may improve practice.

**Recommendation 8: Key lessons learnt from this review around the role of employers in recognising and responding appropriately to domestic abuse issues to be shared with Ms K's previous employers.**

- 6.9.3 In addition to the above, this issue highlighted for the Panel the wide variety of practice that may be present within private companies in regard to domestic abuse, and the importance of increasing awareness where possible of the role of employers and how to recognise and respond to domestic abuse. As a result consideration was given as to how this may be achieved locally, and a route to do so was identified via the Domestic Violence and Abuse Workplace Champions, a network of trained Champions in organisations.

**Recommendation 9: Key lessons learnt from this review around the role of employers in recognising and responding appropriately to domestic abuse issues to be shared with the Domestic Violence and Abuse Champions Scheme for dissemination to companies.**

- 6.10 As a result of discussions around the maximisation of learning from this review, it was agreed that relevant learning should be shared with the National Probation Service on a national level. In addition, while it was Northumberland Children's Services who were involved in this case it was also agreed that relevant learning would be shared by Safe Newcastle with Newcastle Children's Services.

- 6.11 **To what degree could the homicide have been accurately predicted and/or prevented?**

- 6.11.1 As has been outlined throughout this report, there was no information identified, even with the benefit of hindsight, to indicate that the tragic death of Mark could have been predicted by agencies with whom he and Ms K were involved. There was no significant information to suggest he was at direct risk, and indeed the last contact either he or Ms K had with agencies, in relation to concerns around abuse, was more than one year prior to his death.

- 6.11.2 In the year leading up to his death Mark had very limited contact with agencies in any capacity, as did Ms K, and no omissions or failures have been identified that could definitively have prevented the homicide from occurring. However what has been identified is that steps could have been taken to improve agency responses earlier on, or increase community awareness of issues so that abuse hidden to agencies may have been brought to light.

## **7 RECOMMENDATIONS**

### **7.1 Summary of the General Recommendations arising from this Review**

A number of general recommendations from this review have been identified in relation to the lessons learned and these are summarised below. All these recommendations are included in the Action Plan arising from this review and all agencies are requested to feedback regarding the completion of actions via the Safe Newcastle Board.

Recommendation 1: Newcastle Gateshead CCG, NUTH, National Probation Service – North East Region, Northumbria CRC, Northumbria Police, NTW and Northumberland Children’s Services to ensure that key learning from this review around further exploration of presenting issues and the need to gather full social histories, is disseminated to relevant staff and considered in any reviews/audits of training, policy, procedure and practice.

Recommendation 2: Newcastle Gateshead CCG, NUTH, National Probation Service, Northumbria CRC, Northumbria Police and NTW to review their policy, procedure and guidelines for selective and/or routine enquiry in relation to domestic abuse, and ensure that routine enquiry is undertaken where possible. Where selective enquiry is used policy and guidelines should ensure that it would be triggered by the following:

- Presence of substance misuse and/or mental health concerns.
- Expressed concerns regarding relationship difficulties.
- Expressed concerns regarding management of own behaviour or ‘anger’ issues.

Recommendation 3: Newcastle Gateshead CCG to highlight with GP practices the need to ensure that key issues linked to substance use, mental health, or reports of aggressive or abusive behaviour, are highlighted on GP records so that past information can be reviewed and included in consideration of presenting issues.

Recommendation 4: Northumbria Police to review processes in place to alert frontline staff of the need to inform Offender Managers within the National Probation Service and Northumbria CRC of any call outs/concerns in relation to individuals who are being supervised for domestic violence offences. To identify actions to address any gaps found in processes.

Recommendation 5: Newcastle Gateshead CCG, NUTH, National Probation Service – North East Region, Northumbria CRC, Northumbria Police and NTW to ensure that

full information regarding family structure is sought, where appropriate, at initial contact, and reviewed when any concerns around abuse are identified. Any presenting concerns/risks should be considered in relation to any identifiable children or adults with whom individuals may be having contact, and sharing of information with other agencies considered.

Recommendation 6: Newcastle Gateshead CCG, NUTH, National Probation Service – North East Region, Northumbria CRC, Northumbria Police, NTW and Northumberland Children’s Services to ensure that key learning from this review around the dynamics of primary and secondary perpetrators, and the potential risk around retaliatory or defensive violence to all parties, is disseminated to all relevant staff and considered in any reviews/audits of training, policy, procedure and practice. Recommendation 7 (national): Learning from this review to be shared with both Safelives (previously CAADA - Coordinated Action Against Domestic Abuse) and the ongoing review being undertaken by the College of Policing, to request that consideration can be given to issues of primary and secondary perpetrators, retaliatory and defensive violence, and how this may be included in developments around risk assessments and processes.

Recommendation 8: Key lessons learnt from this review around the role of employers in recognising and responding appropriately to domestic abuse issues to be shared with Ms K’s previous employers.

Recommendation 9: Key lessons learnt from this review around the role of employers in recognising and responding appropriately to domestic abuse issues to be shared with the Domestic Violence and Abuse Champions Scheme for dissemination to companies.

## 7.2 Individual Agency Recommendations taken from IMRs.

In addition to the general recommendations outlined above, each agency that undertook an IMR identified individual recommendations to address specific issues identified in their undertaking of the review.

### **Northumbria Police**

- Consideration should be given to a publicity campaign highlighting the Domestic Violence Disclosure Scheme.
- Consideration should be given to reminding officers of the importance of adding appropriate warning markers to better inform the risk. This could be done via a broadcast.

### **Newcastle Gateshead CCG**

- Newcastle Gateshead CCG should continue to promote the need for training in domestic abuse on a three yearly basis and monitor take up of this training.

This monitoring has limitations because of the range of face to face and on line training that could have been undertaken. However, it will give some useful information on the progress being made.

- Alert to be sent to practices within 3 months of the final DHR report with key learning points. Responsible – GP Lead for Adult Safeguarding
- Annual survey of GP practices to include data on domestic abuse training. (March 2015) Responsible – GP Lead for Adult Safeguarding.

### **Northumberland County Council Children’s Services**

- Northumberland County Council Children’s Services identified that there is a recommendation that in this case, during the completion of the PIA in 2010, Children’s Services could have made direct contact with Ms K to seek her views about the situation or, if there was no contact, send a letter to Ms K offering an opportunity to contact children’s services and advising her to access alcohol services and to seek advice around contact through a solicitor if required, given that both parents held Parental Responsibility for their child. This would have more fully completed the Provision and Information Advice record and could have ensured a balanced view of the alleged behaviours of Ms K and potentially encouraged her to access alcohol services at an earlier stage. This procedure is already now in place within Northumberland Children’s Services, following the increased use of PIAs now since 2010.

### **National Probation Service**

- To improve communication between Police and Probation Services in managing the risk posed by Domestic Violence Perpetrators.
- To improve evidence gathering and analysis by NPS staff in managing the risk posed by Domestic Violence.
- To ensure relevant and meaningful contact with offenders in order to manage the risk posed by Domestic Violence.

### **Northumbria Community Rehabilitation Company**

As already outlined, as part of the review process it was identified that the learning identified in relation to the National Probation Service may also have relevance for Northumbria Community Rehabilitation Company (CRC). As a result the information was shared with the CRC and their response sought. This is included in full in Appendix 1 of this report.

**Abbreviations Key**

A&E	Accident and Emergency
CAADA	Coordinated Action Against Domestic Abuse
CCG	Clinical Commissioning Group
CRC	Community Rehabilitation Company
DHR	Domestic Homicide Review
GP	General Practitioner
MARAC	Multi Agency Risk Assessment Conferences
NICE	National Institute for Health and Care Excellence
NPS	National Probation Service
NTW	Northumberland, Tyne and Wear NHS Foundation Trust
NUTH	Newcastle upon Tyne Hospitals NHS Foundation Trust
IMR	Individual Management Review

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**Appendix 1: Northumbria Community Rehabilitation Company – Response to Recommendations of National Probation Service**

It was agreed that the recommendations from the IMR completed by the National Probation Service were relevant to Northumbria Community Rehabilitation Company. This report provides information on the key findings, and comments on what processes are in place to address these and any necessary actions.

The IMR author grouped the key findings under three headings:

- **Communication**

**Action: To improve communication between police and probation services in managing the risk posed by domestic violence perpetrators.**

Procedures are in place for the management of cases with a domestic violence programme requirement (was CDVP, now BBRP or SOLO). At the commencement of an Order the offender manager e-mails through a notification form to the domestic abuse police unit details of the offender, offence, and sentence. This form prompts the police to contact the offender manager if: new domestic incidents have been reported; offender arrested; any other relevant police intelligence comes to notice; any known changes to victim's address. Since August 2013 police arrest data has been received daily from the police and cascaded to teams and offender managers. This arrest data is a prompt for offender managers to contact the police as necessary to make enquiries about the nature of the arrest and outcomes. All offender managers are encouraged to communicate any questions or concerns with the police on any case. The process for actions on the receipt of arrest data is currently under review to ensure that all offender managers follow the same process. This revised "Guidance on Arrest Data" will be cascaded to all offender management staff in Northumbria CRC by 1<sup>st</sup> September 2015.

- **Evidence gathering and analysis**

**Action: To improve evidence gathering and analysis by NPS staff in managing the risk posed by domestic violence perpetrators.**

Northumbria CRC as part of the quality assurance development framework has a Practitioner Advisory Group (PAG). This group designs development improvement activities in response to findings or recommendations from HMIP inspections, lessons from serious further offence reviews, and other quality assurance activities. PAG also supports the practice and professional development of offender managers. Themed workshops have been devised and delivered since September 2014. Within these workshops the issue of considering evidence and applying this to any risk assessment or risk management plans is a key component. In May/June 2015 a specific workshop on working with domestic violence offenders has been delivered to teams. By the end of September the workshop on 'Risk assessment, planning and review' will be delivered to all teams. The organisational development team collate feedback from these team events, which provides evidence that the workshops have been delivered, evidence of the effectiveness and highlights any further areas for development either

individually or as a organisation. There are annual OASys risk assessment quality assurance exercises, the next one will take place over July – September. Part of this quality assurance is reviewing sources of information and how the assessor has applied analysis. Detailed feedback on the quality of the review and any learning points are shared with the offender manager and their team manager.

- **Relevant and meaningful contact with the offender**

**Action: To ensure relevant and meaningful contact with offenders in order to manage the risk posed by domestic violence perpetrators**

The accredited programme available for domestic violence perpetrators is Building Better Relationships (BBRP), this replaced CDVP. If an offender is not eligible or suitable for the programme, there are two other specific interventions for D/V perpetrators - SOLO and Positive Pathways Plus. These are delivered on a one to one basis by the offender manager. SOLO has been available since 2011, and Positive Pathways Plus since April 2015. Probation officers are trained in the delivery of these with the expectation that either SOLO or PP Plus is delivered on cases where the index offence is domestic abuse related. In addition, PP Plus can be delivered to an offender where concerns or issues are raised around domestic abuse during the course of supervision. The delivery of SOLO and PP Plus is monitored via our Delius records system which.

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