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REPORT INTO THE DEATH OF 'Henry'

Executive Summary

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1 INTRODUCTION

1.1 This review was undertaken following the death of 'Henry', who was murdered at his home in late 2014 by his adult son, Graham. Having originally been acquitted of murder, Graham was later found guilty of manslaughter and sentenced to six years imprisonment. His mother was also tried for manslaughter but acquitted.

1.2 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.

1.3 This review examined agency responses and support given to Henry from 1st January 2010 to the point of his death in 2014. As part of the review process Individual Management Review (IMR) reports were completed by Northumbria Police; National Probation Service (NPS); Newcastle Gateshead Clinical Commissioning Group (CCG); Newcastle upon Tyne Hospitals NHS Foundation Trust (NUTH); Northumberland Tyne and Wear NHS Foundation Trust (NTW); and Your Homes Newcastle (YHN). All other Panel members confirmed that their agencies had had no relevant contact with the victim or perpetrator that would warrant the completion of an IMR. As the perpetrator was known to have children, contact was made with Children's Services to see if they had any relevant information. Newcastle Children's Services confirmed that they had no information relevant to this review, other than some basic contact in relation to the child of Graham's ex-partner Angela, details of which were provided and included within this report. This was not felt sufficient to warrant an IMR. In addition, due to information provided by other agencies, Newcastle Children's Services completed a full review of historic records to ascertain whether Graham had himself not been known to them as a child; no records were found. Basic summary information was also provided by the North East Ambulance Service (NEAS).

1.4 Family members were informed of the review process once it was instigated, however direct contact could not take place due to the complexities of the criminal trial, as outlined above. Following the conclusion of the criminal trial, the victim's wife and daughter were contacted on a number of further occasions by both letter and telephone to seek their input into the review; however, no response was received.

1.5 Discussion took place within the Panel as to whether contact should be made with Graham in order to inform the review process. It was felt that, given his continuing denial of the homicide, this would not be appropriate. Information was however obtained from his Offender Manager within the National Probation Service, and this was used to inform the review.

1.6 As part of the review process consideration was also given throughout to issues of equality and diversity. In the cases of Henry, Graham and their family there were no specific issues identified in relation to race, religion, age, sexual orientation, or gender reassignment that were seen to be relevant to the review process. As a male victim of domestic violence, consideration was given within agencies' IMRs, and throughout this review, as to the impact of gender, although this was not seen to be a significant issue in this case.

2 BACKGROUND

2.1 At the time of his death Henry was living with his wife Carol; they had two adult children. Their son Graham was also living with them at the time, this was reported to be following the separation of his own relationship with his most recent partner Angela. The couple's daughter Brenda lived locally.

2.2 The undertaking of this review revealed a concerning and complex history within the Chester family. While regular contact with agencies took place over a prolonged period, the information held by agencies nevertheless presented an incomplete picture, raising a number of questions around the nature of the family relationships and the dynamics of the abuse.

2.3 What emerged, once all agencies information was considered as a whole, was significant evidence of a history of abuse within the family home. While there was only one historic call out to the Police by Sylvia in relation to Henry, she had previously disclosed his violence towards her to health services, and in addition Graham himself told NTW of having being 'beaten' as a child by his father. This was further indicated in Graham's recent contact with the Probation Service, when he disclosed having been both subject of, and witness to, severe domestic abuse within the family home. He had also spoken to his GP of having been 'tortured' as a child, although he did not specify by whom, and had presented from any early age to the GP with injuries.

2.4 In more recent years, and during the time period of the review, there was no reported incidents of ongoing abuse by Henry within the home. However, this lack of report does not necessarily mean absence of abuse, particularly in light of lack of access to information relating solely to Sylvia. Henry's contact with services in more recent years was primarily in relation to his own physical health needs and concerns around his substance misuse and associated mental health needs appear to have diminished.

2.5 During this same period however concerns regarding Graham continued. This was in relation to his own substance misuse, anxiety issues and self harm, as well as his continuing presentation with injuries indicative of him being both the victim and perpetrator of violence. Such concerns were often of a significant level and included stab injuries. His own use of violence was also apparent in relation to Police contact, and the primary victim of this appears to have been his mother. Such concerns were spread out over the time period of the review but there were also 'clusters' of escalation, particularly around 2006. Within his reported behaviour was a concerning level of violence including attempts to 'push out' his mother's eyes, holding a knife to her throat, biting her ear and eyebrow, assaulting her with a golf club, and a report that he had historically burnt her arm causing scarring.

2.6 While Sylvia was the primary focus of Graham's domestic abuse, there were also incidents of reported violence towards Henry in 2002 and 2006, and again these notably involved the use of weapons including a golf club and either a chair leg or a baseball bat. A further question can perhaps also be posed as to whether abuse towards Henry by Graham may have been masked, if it was Sylvia who was most likely to call the police in these circumstances.

3 LESSONS LEARNED AND CONCLUSIONS

3.1 What was concluded from the information available was that Graham's previous levels of violence and use of weapons, were indicative of the fatal level of harm he was capable of causing. However, the target of such violence and the time at which it occurred would have been very difficult to predict based on the information known to each agency at that time. The last report of family violence was in 2012 and related to Sylvia, with no known direct violence towards Henry since 2006. As much of the direct information relating to Graham's violence towards his parents was historic, this also meant that some of the learning identified by agencies had been addressed by changes brought about in ore recent years, particularly the introduction of the MARAC process.

3.2 Just prior to the homicide, Graham's abusive behaviour can also be seen to escalate towards his ex-partner Angela, although, on the basis of disclosure, this related primarily to verbal abuse. He also reported increased anxiety and health issues to his GP, which he related to him having been the previous victim of assaults.

3.3 Within the complex and abusive family dynamic that has been revealed, Sylvia can be seen to have been the victim of violence from both her husband and son over a significant number of years yet, despite periods where she actively reported this, had no known contact with ongoing support services. Henry was a man with a history of both physical and mental health issues, as well as substance misuse issues. His identification as the perpetrator of violence previously, raises the question of whether, as his own health declined, his vulnerability increased in relation to those he had previously abused. In his presentation to services in more recent years however there was nothing known to suggest him to be at risk of abuse. Against this background, Graham has emerged as an individual who has had a high level of exposure to violence, as both a victim and a perpetrator, and whose experiences in early life may well have impacted upon his own use of violence. These experiences may also have links to difficulties in relation to alcohol use, anxiety, and self-harm. Despite this however he appears to have had very limited engagement with services in terms of addressing these underlying issues in any depth.

3.4 **Limited exploration or consideration of issues beyond presenting concerns.**

3.4.1 It was identified by a number of agencies, that while dealing appropriately with the issues presented to them, they did not always fully explore these or consider them within a broader context. This was seen in relation to Graham's repeated presentation to health agencies with injuries, his alcohol use and his repeated self-harm. While it is acknowledged that Graham's own reluctance to explore issues further or disclose, or his level of intoxication at the time, there is also evidence that attempts were not always made to pursue issues. There is also limited evidence that the history and pattern of his presentations was considered, or his own reluctance to engage taken as an indicator for concern in itself.

3.4.2 While there is recognition that much of agencies key contact was historic and thus practice will have changed, this is a learning point that has also emerged in a number of other recent reviews and therefore suggests that work is still needed to embed a culture of professional curiosity, particularly within health agencies. The Panel discussed how despite attempts to introduce policies and procedures such as those around selective enquiry, practitioners do now always identify prompts and continue to work at a 'face value' with presenting issues. An understanding of the dynamics of

abuse and the extent to which this may impact on the way victims present, including under the influence of alcohol, is critical in responding pro-actively to such situations.

3.5 **Lack of follow up and multi agency working**

3.5.1 Expanding upon the previous point, there was also seen to be a lack of follow up to presentations, and within this multi-agency working. While points of good practice were identified in the sharing of information between hospitals and GPs and some referrals being made, there were however other areas where opportunities for further follow up were not taken. These included NPS' lack of exploration with Graham of his alcohol problems and ways to support him in addressing these; and evidence that following incidences of self-harm or reports of increasing anxiety, referrals for assessment or support were not always offered or undertaken. Once again Graham's own reluctance to engage may have impacted on this, but there also remains the question of whether such reluctance, alongside his alcohol use and repeated presentations, may have led to his situation and presentation becoming 'accepted', without full consideration being given to causal or underlying issues and steps that could be taken to address or explore these further.

3.5.2 Such multiple presentations at his GP and hospitals, had they been considered as part of a pattern, should in more recent practice have prompted consideration of Safeguarding Adults. Had this been considered this would have been one avenue by which information could have been shared in a multi-agency setting, which may have assisted in bringing to light the wider picture.

3.6 **Impact of focus on alcohol use in relation to identifying the full extent of the problem.**

3.6.1 It was demonstrated throughout the review, that alcohol use was a significant factor in the lives of Graham, Henry and Sylvia, and there were multiple reports of presentations when they were highly intoxicated. Discussion took place regarding the extent to while the presentation of Graham, Henry and Sylvia to services, in relation to their alcohol use may have 'masked' underlying problems and caused a narrowing of focus in addressing wider issues. It was discussed how multiple presentations under the influence of alcohol may contribute to an acceptance by practitioners that the accompanying presentations were 'normal' and thus an element of acceptance. This was demonstrated in relation to the Police's lack of follow up in relation to Sylvia's reports of domestic abuse, and health services response to Graham's presentation with injuries.

3.6.2 The Panel also discussed how the family may have been viewed by neighbours and the extent to which 'disturbances' may have been considered part of their presentation that came to be accepted and thus not alerted or reported. This was starkly demonstrated in relation to the day of the homicide when a neighbour reported to Graham's sister that they had heard the brother 'beating up' their parents that morning, yet they had not contacted any services in relation to this.

3.7 **'Think Family'**

3.7.1 One further final area of concern was the extent to which this review, even with the benefit of hindsight and the sharing of information by all agencies, had difficulty in

identifying the children involved in the situation. There is reference within Police and Probation records to Graham having had a child or children in previous relationships, and to his ex-partner having a child, however it appears that this was not known, or at least recorded, in relation to his contact with most agencies. In light of this any presenting concerns were not then considered in relation to any risk he may pose to children he was having contact with. Once again this is a learning point identified recently in other local reviews. As such recommendations have recently been made for all agencies to sure that full information is gather regarding social and family histories, so that any risk can be considered within this context. All agencies should therefore ensure that actions arising from these previous recommendations are being enacted.

4 RECOMMENDATIONS

Summary of recommendations arising from this review

National:

- Safe Newcastle to notify Home Office of ongoing difficulties impacting on review process when GPs feel unable to fully engage in the sharing of information.

Regional:

- Learning and actions for National Probation Service to be shared with Northumbria Community Rehabilitation Company for consideration in relation to ongoing practice.

Newcastle Gateshead Clinical Commissioning Group

- GP surgery to ensure systems are in place to review information received from sources such as hospitals and flag any concerns appropriately on patient records.
- CCG to identify actions that can be taken to ensure that repeated learning from homicide reviews around the need to consider historical information and fully explore presenting concerns, is being actively addressed within practices.

Northumbria Police; National Probation Service; Newcastle upon Tyne Hospitals NHS Foundation Trust (NUTH); Northumberland, Tyne and Wear NHS Foundation Trust (NTW);Your Homes Newcastle (YHN)

Individual agency recommendation identified within IMRs

Northumbria Police

- Further input needs to be given to 24/7 and Neighbourhood Officers regarding fully updating the electronic DV screens with regard to actions taken and the rationale behind those actions. This could be achieved by way of an internal communication circulation.

National Probation Service

- The author identified that they believed the case highlights the importance of conducting at least one home visit to an offender, and that this should where possible be conducted regardless of the level of assessed risk. Clearly operational commitments dictate the feasibility of home visits being conducted on every case, however if such visits can give even the slightest indication of abusive behaviour within a family home, then this in itself could prove an effective method of protecting others from serious harm or even death.

Newcastle Gateshead Clinical Commissioning Group

- All GP's and clinical Staff at the GP practice should attend Domestic Violence Training sessions. Such training is available from Newcastle City Council or via NHS Newcastle Gateshead Safeguarding Adults Team. A register should be kept of those attending training and refresher training should be booked in accordance with the safeguarding adults policy.
- The findings of local research around the outcomes of DHR should be recirculated to all GPs to ensure lessons learned are disseminated as this may allay genuine anxieties for GPs when asked to share information and participate in future review. This has already been incorporated into Domestic Violence Training materials in a recent revision. The report will be recirculated via Practice Managers and Safeguarding Leads.

Newcastle upon Tyne Hospitals NHS Foundation Trust (NUTH)

- To maintain levels of training and awareness of Domestic Abuse for staff within the Trust.
- To continue to raise awareness of the Adult Safeguarding Team who are available to offer support and advice to staff, and their role within the organisation,
- To continue to raise the profile of Adult Safeguarding within the organisation, ensuring that staff have a clear understanding of partnership working with internal and external agencies which achieves best practice and outcomes for patients.

Northumberland, Tyne and Wear NHS Foundation Trust (NTW)

No recommendations were identified in this case specific to NTW, due to the historical nature of involvement and policies and processes regarding Domestic Abuse that are now in place for staff. However, it was noted that consideration of a multi-agency learning event on "working with family members in a household who abuse alcohol and the impact this has on relationships and their vulnerability" maybe of benefit for agencies to learn from each other.