

THE CONTENT OF THIS REPORT IS RESTRICTED UNTIL PUBLICATION

REPORT INTO THE DEATH OF 'Joe' and 'Iris'

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1. INTRODUCTION

- 1.1 This review related to the homicides of ‘Joe’ (aged 64) and ‘Iris’ (aged 54) at their home in December 2014; their son Bob (aged 28) was convicted of their murder. The case therefore met the criteria for a statutory Domestic Homicide Review.
- 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 The time period covered by the review was from 1st October 2012 until the day of the homicides. As part of the review process Individual Management Review (IMR) reports were completed by Newcastle Gateshead Clinical Commissioning Group (CCG); South Tyneside Clinical Commissioning Group (CCG); Newcastle upon Tyne Hospitals NHS Foundation Trust (NUTH); Northumberland Tyne and Wear NHS Foundation Trust (NTW); Adult Social Care, Newcastle City Council, Wellbeing Care and Learning Directorate (ASC); and Your Homes Newcastle (YHN). All IMR authors were independent of the case and had no previous contact with Joe, Iris or Bob, either as a practitioner or through the management of staff involved. The Independent Chair/Overview Report Author for the review did not work for any of the agencies involved and had no involvement with Iris, Joe or their son, or any supervisory responsibility for any of the professionals’ work being reviewed.
- 1.4 The specific Terms of Reference agreed for this review were:
 - Were there any indications of difficulties within family relationships?
 - Was there any history of abuse by Bob towards his parents or towards others, including his wife or children?
 - Were there indicators of vulnerability in relation to Joe or Iris? Were there any indicators that Bob had a caring role within the family?
 - Were there any concerns relating to substance use or mental health issues in the case of either the victims 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 violence or abuse, substance use and/or mental health issues, may have led to any ‘narrowing of focus’ and the failure to explore other issues.
 - Were there any indicators of any financial difficulties? If so, to what extent may they have impacted upon family relationships?
- 1.5 The review process was not completed within six months due to a number of reasons. Firstly, completion of IMRs led to identification of a further IMR being required from South Tyneside CCG. Secondly, the family could not take part in the review until the trial had concluded; this was due to their potential involvement in the court case. Upon conclusion of the trial, a meeting took place with Iris’s daughter Charlotte; this raised a significant concern regarding a 999 call that was placed by her mother on the day of the homicides. As all other information had been reviewed regarding agency contact and relevant action taken, the Panel agreed it was acceptable to extend the timeframe of the review in order to fully explore issues regarding this 999 call. The purpose of this was to ensure that the steps being undertaken to review the call were comprehensive, and to decide whether a separate IMR was required for the purpose of this review. It took considerable time to obtain the relevant information and satisfy the Panel that sufficient consideration had been given to this issue within other review processes. This significantly impacted upon the timescale for completion of this final report, although any actions identified by

agencies were not delayed as a result.

- 1.6 In addition to the above, Joe and Iris's daughter, Charlotte, agreed to meet with the Chair as part of the review process and contributed extensively, including the provision of a statement to the Panel, this extended the timescale further.

Other Reviews

- 1.7 As already indicated, Information obtained during the course of this review indicated that a 999 call had been placed by Iris on the day of the homicides, and that this was reviewed by BT, the 999 liaison committee, and the National Police Chiefs Council's Contact Management Steering Group. As this was a significant event prior to the homicide, and an issue raised by Iris's daughter Charlotte, the extent and outcome of the review by these other bodies was considered fully by the Panel.
- 1.8 Charlotte had also made a complaint to Northumbria Police regarding the Police's conduct of the investigation, and the focus on Bob as the alleged perpetrator. This matter was dealt with separately and was not relevant to the terms of reference of this review.

2 BACKGROUND

- 2.1 Joe and Iris were a white British couple who married in 2001, and were living together in the Newcastle area at the time of their deaths. As well as having an adult son together, Bob, both Joe and Iris each had an adult daughter from previous relationships.
- 2.2 In June 2006 Iris had an operation to remove a benign brain tumour and post operatively suffered a stroke, following which she received many years of neurological rehabilitation, and required some care and support within the home. During this time Joe acted as her primary carer.
- 2.3 The couple's son Bob had been married previously, and had two children within this relationship. He was believed to be separated from his wife at the time of the homicides and residing with his parents.
- 2.4 The undertaking of this review revealed limited contact with agencies by Iris or Joe, outside of that related to Iris's health and social care needs following her surgery in 2006 and the post operative stroke that she suffered. Subsequent to this Iris was in regular contact with NUTH, NTW, her GP and Adult Social Care, and within this Joe was identified as her main carer, himself presenting to his own GP in 2006 and 2007 with difficulties that appeared related to him coming to terms with his wife's condition. Such contact decreased over the years and from 2008 onwards the primary contact Iris had was in relation to her continued attendance at the Neurological Rehabilitation Clinic until 2014.
- 2.5 The picture that emerged was of Joe and Iris as a relatively private couple, and as a result little information has emerged to present any clear picture of their family life by agencies, beyond that relating to Iris's recovery and Joe's role in caring for her. Within this, there has been some reference to their son Bob, who appeared to live with them for periods of time, and was mentioned by a number of agencies as attending appointments with Iris and offering support.
- 2.6 As regards Bob, outside of his contact with professionals working with his mother, he also

had limited involvement with agencies. He had no known history of violence or abuse, and indeed there were no indicators of this in his presentation to agencies working with his mother.

3 LESSONS LEARNED AND CONCLUSIONS

- 3.1 In reviewing agencies contact with the family there was no evidence of any abuse, or any missed indicators. There was also evidence that both Joe and Iris were seen alone by agencies, giving them the opportunity to disclose any concerns.
- 3.2 In hindsight, it was identified that there were indicators of concern around Bob in the months leading up to the homicide. These included his apparent separation from his wife, the possible loss of his home, and difficulties reported to his GP. The only agencies that held relevant information in relation to Bob were the two GP practices with whom he was registered during the review period. It was shown that he presented on a number of occasions, over a period of years, with complaints of anxiety and stress and persistent headaches. Relatively close to the homicides, in September 2014, he presented with similar complaints but also reported that his father had committed suicide. The reason for such a fabrication remains unknown. What is apparent is that when he also made disclosures of concern around his relationship with his partner, children and mother, these were seen in light of his report that his father had died, which contributed to such disclosures not being pursued further. Indeed, the learning identified from this review, though limited, focused on the need to gather further information around people's home circumstances when stress or anxiety is reported, and to explore disclosures of conflict or distress in more detail. This can be seen to be particularly important in relation to the role of GPs, for as this review has demonstrated, in cases where individuals such as Bob have little contact with agencies, the GP may be the only one to whom any concerns are expressed.
- 3.3 It was concluded that as a result of the limited nature of contact with agencies, the absence of any known history of violence, and the absence of any indicators of abuse by Bob towards his parents, the agencies involved in working with Iris, Joe or Bob, had no information available to them that would have allowed them to predict or prevent the tragic and untimely deaths of Iris and Joe.

Day of the homicides

- 3.4 According to information made available to the review, on the day of her death Iris placed a 999 call which was received by the British Telecom, who act as the 'Call Handling Agent' (CHA) for the emergency services and route emergency calls to appropriate services.. The day to day operational practices and procedures that are adopted between the CHA and the emergency services are documented in Public Emergency Call Service Code of Practice (PECS Code of Practice).
- 3.5 Information provided indicated that the handset was replaced at the caller's end after three seconds. There was said to be no signs of disturbance or distress, and though a brief muffled voice could be heard, what was being said was indistinguishable. During the criminal investigation, enhancement equipment was used on the call, which revealed that something such as 'please hurry up' may have been said. However, it was not believed this would have been heard by the operator handling the call. The operator was reported to have stayed on the line for a further forty five seconds after the handset had

been replaced, thus keeping the line open should the caller wish to re-engage. As there was no indication of distress, and no further communication was received, the call was not connected to the Police.

- 3.6 Information provided by BT indicated that about 30 million emergency calls are made each year from both fixed lines and mobile handsets. Call filtering for silent or near-silent calls where the caller does not, or cannot, respond to the 999 operator with a request for a given service (Police, Fire, Ambulance or Coastguard), means that calls are not always connected on to an emergency service. BT carries out this filtering at the request of the Police and uses processes agreed with them within PECS. Each day, approximately 20,000 calls are handled using these filtering processes, with about ten percent of these, in which there is no direct request for connection by the caller, being connected to the Police because there are some audible signs of distress or disturbance. In the case of Iris's call it was concluded that there were no audible indications on the call from Iris, with this only becoming known after the event when the call was enhanced for the criminal trial. As such the call was not connected, which was in line with the PECS code of practice.
- 3.7 A similar incident to that of Iris's call, also occurred in Wales previously and both calls were reviewed by the UK Government's 999 Liaison Committee, in relation to how BT is required to filter calls on behalf of the Police to see whether any improvements could be made. This was then referred to the National Police Chiefs Council's Contact Management Steering Group, who have responsibility for the development and implementation of policy in this area. This Group met on 29/09/15 and, taking both cases into account, concluded that with existing technology, the filtering process could not practically be improved.
- 3.8 Iris and Joe's daughter Charlotte raised a number of issues regarding this process and the subsequent conclusions drawn by the reviewing committees.
- 3.9 It was difficult for the Panel to draw any further conclusions, particularly given the lack of access to first hand sources around the call. Consideration was given as to whether an IMR as needed in relation to this, however information supplied by the 999 Liaison Committee suggested this issue had been reviewed in detail by themselves and the National Police Chiefs Council's Contact Management Steering Group; the Panel felt these were the appropriate and best placed avenues to review such concerns. All parties were made aware of Charlotte's concerns.

4 FAMILY PERSPECTIVE

- 4.1 Charlotte participated extensively in the review process and provided a valuable picture of her family. As already indicated she identified a key issue in relation to the 999 call, as well as having raised concerns regarding the investigation of Iris and Joe's murder, which was being dealt with separately. In addition however, she also raised concerns about the availability, independence, and level of support offered by the Police's Family Liaison Officer and Victim Support. She felt that at time their roles were unclear and indistinct. She said that the liaison between the two meant that she did not feel entirely comfortable in talking openly, given the police's involvement in the investigation of her brother. Charlotte also felt that more signposting should have been provided around who could provide support for her young son to deal with the impact of the murder of his grandparents. She spoke of how this was not forthcoming and initially left him without

access to appropriate support, which was eventually obtained through her husband's employers. As a result of these latter issues, a recommendation was made by this review to enable Charlotte's concerns about her experiences as a family member to be considered in more detail. The comprehensive document written by Charlotte relating to her concerns was also shared with Panel members for consideration by all agencies.

5 RECOMMENDATIONS

5.1 Summary of recommendations arising from this review

Victim Support and Northumbria Police

- Meeting to be offered to Charlotte to consider her experience following the murder of her parents and whether this can be used to inform processes and support offered to family members.

South Tyneside Clinical Commissioning Group

- Where patients are presenting with mental health concerns and management of this is based on reports that they are receiving support from other sources, GPs should be encouraged, where possible, to verify this.

5.2 Individual agency recommendation identified within IMRs

Newcastle Gateshead Clinical Commissioning Group

- All GP Practice staff should be encouraged to attend Domestic Violence training to raise their awareness of this issue, have regard to the impact of domestic violence upon the wider family unit and to recognize the interface between safeguarding and domestic abuse. The training is available from Newcastle City Council and/or the safeguarding teams from NGCCG. An annual audit of training undertaken will be done by the Safeguarding Adults Lead NGCCG. Responsible – GP Lead for Safeguarding Adults NGCCG.
- NGCCG should continue to support GP Practices across the City to promote the needs of carers within Primary Health Care Teams. Responsible – Medical Director for NGCCG in partnership with the Clinical Strategic Director, Newcastle Unit of Delivery.
- This review highlights that GP's and Clinical Staff in primary care need to explore the wider implications, and potential risks, of an individual's presentation and behaviours. The 'Think Family' agenda includes children and others with vulnerabilities; this issue will be emphasised in training. Responsible – GP Lead for Safeguarding Adults NGCCG, Adult Safeguarding Leads in GP Practices and the Safeguarding Adults Team, NGCCG.

South Tyneside Clinical Commissioning Group

- All GPs should be aware of the correlation between poor mental health substance misuse and domestic abuse to ensure exploration of all issues and appropriate actions can be made to ensure the safety and welfare of all.
- All GP Practices should routinely enquire and document next of kin / partner / children details at the point of registration and updated as required, to ensure the appropriate support and interventions can be offered.

Adult Social Care, Newcastle City Council, Wellbeing Care and Learning Directorate

- Ensure a clear record of all changes to care packages is entered on Carefirst by Social Work staff.