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NEWCASTLE DOMESTIC HOMICIDE REVIEW

INTO THE DEATH OF 'Mark'

Executive Summary

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1. Introduction

This review was undertaken following the death of 'Mark', who was murdered in early 2014 by his partner, Ms K. In January 2015, Ms K pleaded guilty to manslaughter and, following preparation of psychiatric reports in which it was agreed that she had amnesia in relation to her commission of the offence, was later sentenced to seven years imprisonment,.

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.

This review examined agency responses and support given to Mark prior 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, 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 Service; and ESCAPE Family Support. It was also agreed that the recommendations from the IMR completed by the National Probation Service were relevant to Northumbria Community Rehabilitation Company, who provided a report with comments on what processes are in place to address the key findings, as well as any necessary actions. They also agreed to implement any general recommendations arising from the review.

The time period covered by the review was from 1st January 2010 to the day of the homicide. Any relevant and significant events prior to this review period were also included where they provided context to the homicide, the risk posed by the alleged perpetrator, or the vulnerability of the victim or children.

Mark's parents, sister, and his ex-wife declined to be involved in the review process; as did Ms K's ex-partner. The review did however have access to witness statements, and this provided a broader view of Mark and Ms K's relationship.

In addition a meeting took place with Ms K's manager from her previous employment, as well as with Ms K.

2. Background

At the time of his death Mark was living with Ms K. Information available to the review indicates that Mark and Ms K had been in a relationship since early 2010. They had no children together.

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. 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.

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.

3. Lessons Learned and Conclusions

It emerged throughout the 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. 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 indicated 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.

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.

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 involved 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.

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.

3.1 Lack of further exploration of presenting issues and the 'toxic trio'

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 mental health assessment appointment with NTW's 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.

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.

3.2 Silo working and a lack of information sharing or follow up

What emerged 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 emerged 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, and that this may have widened the perspectives of some of the agencies involved.

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.

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.

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.

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.

3.3 'Think Family'

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.

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.

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.

3.4 Understanding the dynamics of the domestic abuse and the issue of gender

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.

Very little was 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.

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, which 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 alleged that 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.

It is impossible to know for sure the full extent or nature of the abuse between Mark and Ms K, although the information available to agencie, 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.

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, suggested 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.

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 that the opportunity to further consider and explore his presentation with scratches to his face during an incident to which police were called.

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 with 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 issues was 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 introduced 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.

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.

What therefore can we learn from all the above? With the benefit of information obtained from family and friends' witness statements 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, her 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.

What this highlights, is that risk assessments or processes that are used by agencies are often 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[1] 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'.

[1] 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'.

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

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

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 awarness of what friends and family can do in cases of domestic abuse.

Finally, it was also 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.

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 within organisations.

4 RECOMMENDATIONS

A number of general recommendations from this review were identified in relation to the lessons learned and these are outlined below.

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.

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.