



## **DOMESTIC HOMICIDE REVIEW EXECUTIVE SUMMARY:**

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## **Executive Summary**

### **1. Introduction**

This Domestic Homicide Review (DHR) examines the circumstances around the death of Mr A and the responses of agencies who had involvement with the victim and one of the perpetrators, Miss B. While the exact date of death remains unknown, the review covered the period from 1 July 2010 to 1 December 2012, the date when Mr A's body was discovered. The exact date of death was unknown.

Mr A's ex-partner, Miss B and another male, Mr C, were convicted of his murder and sentenced on 25 July 2013 to life imprisonment with minimum terms of 25 and 23 years respectively. It has been difficult to gain a clear picture of the nature of the relationship between Mr A and Miss B. As far as we can surmise, Mr A and Miss B only lived together for a few weeks in early 2012 and there was no contact between them between 5 March 2012 and the time of the murder.

### **2. The Review Process**

Following initial investigation of the murder, Northumbria Police notified the Chair of Safe Newcastle for the case to be considered for a Domestic Homicide Review. The Chair confirmed with the Home Office that this case met the criteria set to establish a domestic homicide review.

The initial DHR panel meeting was held on 29 January 2013 and attended by agencies that potentially had contact with the victim and perpetrators.

The participating agencies were as follows:

- Safe Newcastle Unit, Newcastle City Council
- Northumbria Police
- Safeguarding Adults, Newcastle City Council
- Your Homes Newcastle
- North East Ambulance Service
- Northumberland Tyne and Wear (NTW) NHS Foundation Trust
- Newcastle upon Tyne Hospitals

- Newcastle North and East and Newcastle West Clinical Commissioning Groups
- Victim Support

From this panel meeting it was agreed that the first task was the preparation of chronologies of any involvement with the victim, Mr A or the perpetrators. These chronologies were primarily focused on the time period from 1 July 2010 to 1 December 2012 in line with the terms of reference of the review. However, relevant historical agency involvement was also to be provided. This was to gain an overview picture of agency involvement and in order to determine which agencies should prepare Individual Management Reports (IMRs) to contribute to the Overview report.

Subsequent panel meetings were held on 13 March 2013 and 10 May 2013. The terms of reference of the review were agreed and identified agencies required to complete IMRs. Six agencies were identified as having had contact with the victim and perpetrators. It was apparent that there had been limited agency contact with the victim, Mr A, whilst a number of agencies had contact with the perpetrator, Miss B, both within the timescale of the review and historically. The agencies required to complete IMRs by 29 July 2013 ahead of the next panel meeting on 16 August 2013 were:

- Northumbria Police
- Newcastle City Council Adult Services
- Your Homes Newcastle
- Northumberland Tyne and Wear NHS Foundation Trust
- Newcastle upon Tyne Hospitals NHS
- Newcastle North and East and Newcastle West Clinical Commissioning Groups

All completed IMRs were submitted for 29 July 2013 and, at the panel meeting on 16 August, a two-month timescale was set for the completion of the first draft of the Overview Report. The production of IMRs confirmed that agencies had significantly more involvement with the perpetrator, Miss B, than with the victim, Mr A and that much of this involvement had been with her as a potential victim of domestic violence

and sexual abuse. It was agreed that there was no significant agency involvement with the perpetrator Mr C so he was not included in the review.

The review has extended beyond the stipulated six-month timescale. This has been due to:

- delays in the amalgamation of agency chronologies
- inviting additional agencies onto the Review Panel
- seeking consent from the perpetrators for disclosure of relevant records from some organisations
- awaiting the outcome of the criminal trial
- interviewing the perpetrator Miss B in custody
- undertaking re-drafts of the overview report as agreed by the Panel

The Safe Newcastle Unit sought and were granted a period of extension for completion of the review from the Home Office. Lessons have also been learned from the delays outlined above that will be considered within future review processes to try to ensure more timely completion of the reviews.

### 3. Terms of reference

The purpose of the Domestic Homicide Review is to:

- Establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims
- Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result
- Apply these lessons to service responses including changes to policies and procedures as appropriate and
- Prevent domestic violence homicide and improve service responses for all domestic violence victims and their children through improved intra and inter-agency working.

In order to achieve these outcomes, the panel agreed that the focus of the report should be on a number of specific areas of practice in relation to participating agencies:

1) A number of primary incidents were identified within agency chronologies as significant in the relationship between Mr A and Miss B. In relation to these incidents consideration was to be given to any contact the agencies had with those involved around the time of the incidents, including addressing the following questions:

- How were the incidents recorded? Were they identified as domestic violence incidents?
- Were any risk assessments undertaken? What were the conclusions? In cases where they were not, why was this decision taken?

- What plans were put in place to address any risks that were identified? In cases where no plans were identified, why this was decision taken?
- Was relevant information shared with other agencies? How? If not, why was the information not shared?
- Was any multi agency working undertaken? What did this involve? What were the results? Were there any difficulties in undertaking this?

2) Issues relating to Miss B's mental health and how this was identified and addressed.

3) Issues relating to the alcohol use of all parties, the extent to which this was identified as playing a part in the relationship between them, and how this was addressed.

4) Within the chronologies a number of references were made within agency records to 'partners' without it being made clear as to whom this referred. It was been identified that this may be one of the lessons to be learnt around clarity required in recording. This should therefore be further considered within the review.

5) Within the chronologies a gap was identified between September 2009 and March 2012 when the perpetrator, Miss B, appeared to stop accessing all services. The review was to be aware of this and seek to identify any further information available that may indicate why this was the case, or whether Miss B accessed other services during this time that should be included within the review.

The following questions were also agreed for consideration in relation to any agency contact with the parties involved:

- Were practitioners sensitive to the needs of the victim and the perpetrator, knowledgeable about potential indicators of domestic violence and aware of what to do if they had concerns about a victim or perpetrator?

- Was it reasonable to expect them, given their level of training and knowledge, to fulfill these expectations?
- Did the agency have policies and procedures for risk assessment and risk management for domestic violence victims or perpetrators and were those assessments correctly used in the case of this victim/perpetrator?
- Did the agency have policies and procedures in place for dealing with concerns about domestic violence?
- Were these assessment tools, procedures and policies professionally accepted as being effective?
- Did the agency comply with domestic violence protocols agreed with other agencies, including any information-sharing protocols?
- What were the key points or opportunities for assessment and decision making in this case?
- Do assessments and decisions appear to have been reached in an informed and professional way?
- Did actions or risk management plans fit with the assessment and decisions made? Were appropriate services offered or provided, or relevant enquiries made in the light of the assessments, given what was known or what should have been known at the time?
- When, and in what way, were the victim's wishes and feelings ascertained and considered. Is it reasonable to assume that the wishes of the victim should have been known? Was the victim informed of options/choices to make informed decisions? Were they sign-posted to other agencies?
- Had the victim disclosed to anyone and if so, was the response appropriate?

- Was this information recorded and shared, where appropriate?
- Were procedures sensitive to the ethnic, cultural, linguistic and religious identity of the victim, the perpetrator and their families? Was consideration for vulnerability and disability necessary?
- Are there other questions that may be appropriate and could add to the content of the case? For example, was the domestic homicide the only one that had been committed in this area for a number of years?
- Are there ways of working effectively that could be passed on to other organisations or individuals?
- Were senior managers or other agencies and professionals involved at the appropriate points?
- Are there lessons to be learned from this case relating to the way in which this agency works to safeguard victims and promote their welfare, or the way it identifies, assesses and manages the risks posed by perpetrators?
- Where can practice be improved? Are there implications for ways of working, training, management and supervision, working in partnership with other agencies and resources?
- How accessible were the services for the victim and perpetrator?
- To what degree could the homicide have been accurately predicted and prevented?
- Consideration should also be given to whether MARAC and MAPPA processes should have been instigated, although there is no information at this time to suggest this to be the case.



#### **4. Key issues arising from the review**

There is limited information available about the relationship between Mr A and Miss B and very little to suggest that Mr A would be a victim of domestic homicide. Some detail of the relationship did emerge from the criminal trial, primarily from prosecution witnesses, who described the controlling nature of the relationship, with Miss B exerting financial and sexual control over Mr A. However, even this information does not provide a clear picture of the nature of the relationship.

Miss B has a long history from 1989 of accessing services in relation to mental health, housing and physical health needs. She had intermittent involvement with agencies during the period in consideration in this report, July 2010 – December 2012.

Both Mr A and Miss B made allegations of Domestic Violence against the other and both were recorded by Police as the victim in separate incidents. Miss B was reported to have assaulted Mr A in January 2011 and he was seen to have a facial injury on this occasion. Miss B was recorded as the victim following a verbal dispute in May 2011; no action was taken in either of these incidents. Mr A was arrested following an allegation of sexual assault by Miss B in March 2012. Again, no further action was taken on this matter. Miss B alleged to Health and Social Care professionals on a number of occasions that she had been subject to physical, sexual and emotional abuse. However, there was a lack of clarity about the nature of the allegations and against whom they had been made.

One of the features of this case is that agencies had very little contact with the victim, Mr A. Both historically and during the period of agency intervention being considered by the DHR, agencies had intermittent contact with the perpetrator, Miss B. During this contact she disclosed on a number of occasions that she was a victim of domestic abuse, both historically and from Mr A. In considering responses to these disclosures, it appears that professionals from agencies made initial positive responses to these disclosures. However, there is a pattern of these initial disclosures not being followed up by the workers to whom the disclosure had been

made, rather focusing on the practical tasks in hand. In mitigation, it appeared that Miss B's focus was also often on practical concerns.

One of the other features of agency engagement with Miss B was that, following disclosures of domestic abuse, the identity of the partner / ex-partner was either not asked or not recorded. This was both historical and within the timeframe of the DHR. This has contributed in part to the lack of clarity about the nature of the relationship between Mr A and Miss B. It also contributed to the failure of agencies on occasions to link separate incidents as the identity of the partner / ex-partner to whom she was referring was not clear.

## **5. Lessons to be learnt**

This case is unusual in that, with the exception of one incident, there was no information available to suggest to agencies participating in the review that Mr A was a victim of domestic violence. This has led to the key points of learning from this review being largely focused on agency responses to the perpetrator, Miss B, in relation to her presentation as a victim of domestic violence. In doing this we are in no way taking any stance in relation to the veracity of her allegations against Mr A. We are simply seeking what lessons can be learnt in relation to agency responses to any person who presents as a potential victim of domestic violence. It is important to view the response of agencies in light of how little was known about the nature of the relationship between Mr A and Miss B at the time of these allegations being made, together with the knowledge that Miss B had previously been a victim of domestic violence and seen as generally vulnerable.

The key points of learning for agencies participating in this DHR are as follows:

- **Dealing with disclosure of domestic abuse**

Miss B's disclosures to a number of agency staff, particularly in relation to an allegation of sexual assault, were documented in agency records. In some cases this information was shared with other agencies. However, there was a pattern of staff not picking up on initial disclosures in subsequent contacts with Miss B, rather

choosing to focus on the task in hand. There was also a failure of staff to consistently seek and record the identity of partners and ex-partners to whom she was referring.

- **Improving recognition of risk around disclosure of sexual assault / rape and response to this**

Agencies failed to recognise that the disclosure of sexual assault by Miss A potentially presented a high level of risk in this case. Initial disclosure was facilitated but not followed up through clarification of information or undertaking of risk assessments.

- **Working with clients with complex needs particularly mental health and alcohol use**

One of the features of this case was the complexity of needs presented by the perpetrator Miss B. The presenting issues were particularly around alcohol and mental health. Indeed Miss B's alcohol misuse was a feature in a number of the key incidents. There is an acknowledgement from participating agencies that she was not easy to engage, that she would neither acknowledge nor willingly address either of these issues. This again highlights a training need in relation to staff focusing on assessing risk and devising support plans in response to information presented rather than the presentation of the individual victim and how easy or otherwise it is to engage with them.

- **Assumption that other agencies will address the risk**

In addition to a lack of confidence in taking forward initial disclosure of domestic violence to explore further, there were a number of occasions when agency staff made assumptions that their task was completed when they had shared information. This was particularly the case in relation to the incident when Miss B alleged that Mr A had sexually assaulted her. Through the process of the review Safe Newcastle and Newcastle Adult Services have developed a multi-agency domestic violence and abuse procedural flowchart outlining the process of dealing with disclosure and undertaking risk assessments with adults. This represents a positive step in seeking to improve inter-agency information-sharing and bring consistency to risk assessment.

- **Risk assessment not consistently undertaken**

All participating agencies barring GP services have domestic violence risk assessment procedures in place and use accredited risk assessment tools. Work is underway with GP services to institute procedures and increase familiarity with risk assessment tools. However, in this case, risk assessments were only undertaken by the Police at the scene of reported domestic abuse incidents and by Mental Health Services in relation to Mr A's risk of self-harm. No risk assessments were undertaken in response to disclosure of domestic abuse by Miss B. In some cases, the staff did not follow procedures by sharing information with line managers who were trained to undertake domestic violence risk assessments. These omissions may have been down to a lack of awareness of agency procedures in relation to risk assessment or the assumption that risk was being addressed elsewhere, particularly by the police.

- **Identifying and working with male victims of domestic violence**

There was very little information available in relation to agencies identifying Mr A as a potential victim of domestic violence and to understand the nature of power dynamics that were present in his relationship with Miss B. However, it is important to highlight the issues of men being identified as potential victims of domestic violence as a learning point of this review. In relation to this case, there are some features that are indicative of the research findings, namely the difficulty of identifying who was the primary perpetrator, the presence of mental health and alcohol as contributing factors. Participating agencies have acknowledged the importance of being more able to identify where men are victims of domestic violence and ensuring that this is incorporated into delivery of domestic violence training.

## **6. Recommendations**

The following recommendations are those agreed by the panel, as these relate to crosscutting issues affecting more than one agency.

- 1) All agencies to identify, and feedback to the Safe Newcastle Unit, whether key learning points from this review are already addressed in their existing local training programmes, and actions to be taken to incorporate it where gaps are identified. The key learning points have been identified as:

- Ensuring that, when there is disclosure of Domestic Violence, this is followed through and remains a focus of intervention, particularly where Domestic Violence is not the primary remit of the agency. This includes taking full details of the event and alleged perpetrator.
  - Ensuring staff understand the level of risk associated with disclosure of sexual assault / rape and the responses required as a result of this.
  - Working effectively with clients with complex needs, particularly mental health and alcohol use, who are disclosing issues of domestic violence.
  - Agencies to ensure that staff are aware of procedures following disclosure of domestic violence and that these are followed through fully, regardless of whether other agencies are involved in the case. This particularly applies to cases where there are criminal investigations or even proceedings.
  - Identifying and working with male victims of domestic violence
- 2) To improve recognition of risk associated with disclosure of sexual assault / rape and the responses of agencies.
- 3) Agencies to disseminate the Newcastle Multi-Agency Domestic Violence and Abuse Procedural Flowchart for Adults to all staff. Feedback is to be provided to the Safe Newcastle Unit as to how and when this has been achieved.

