Cheshire West & Chester
Community Safety Partnership

Domestic Homicide Review

George
Died June 2018

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Date: 4 June 2019

INDEX

		Page
1	Introduction	2
2	Timescales	3
3	Confidentiality	3
4	Terms of Reference	4
5	Methodology	7
6	Involvement of family, friends, work colleagues, neighbours and wider community	7
7	Contributors to the review	11
8	The review panel members	13
9	Author of the overview report	13
10	Parallel reviews	13
11	Equality and Diversity	14
12	Dissemination	16
13	Background information (the facts)	16
14	Chronology	18
15	Overview	26
16	Analysis	29
17	Conclusions	50
18	Learning	52
19	DHR Panel recommendations	52
20	Appendix A Action Plan	54

1 INTRODUCTION

1.1 This report of a domestic homicide review examines agency responses and support given to George[1], a resident of Cheshire West and Chester prior to his murder in June 2018. The DHR panel would like to express their condolences to George's family on their devastating loss.

1.2 In addition to agency involvement the review will also examine the past to identify any relevant background or trail of abuse before the homicide, whether support was accessed within the community and whether there were any barriers to accessing support. By taking a holistic approach the review seeks to identify appropriate solutions to make the future safer.

1.3 George lived with his wife Mary[2] and son Peter[3] at the family home in Cheshire West and Chester. His other son Nathan[4], had a flat a few miles away, but stayed with the family from time to time. Nathan was staying at the family home in June 2018, when George was fatally stabbed by Nathan in the downstairs of the house. George suffered nineteen wounds and had no defensive injuries. Nathan was arrested at the scene and was later charged with George's murder which he was found guilty of at Liverpool Crown Court. He was sentenced to life imprisonment with a minimum term of 16 years.

1.4 The review will consider agencies contact/involvement with George, and Nathan from 1 April 2014 to George's murder in June 2018. This was thought to be a proportionate and sufficient period as immediately prior to this Nathan had experienced a settled period after moving into his own home before coming to the attention of the Police in April 2014. Information prior to this period is included in this report to give context.

1.5 The intention of the review process is to ensure that agencies are responding appropriately to victims of domestic violence and abuse by offering and putting in place appropriate support mechanisms, procedures, resources and interventions with the aim of avoiding future incidents of domestic homicide, violence and abuse. Reviews should assess whether agencies have sufficient and robust procedures and protocols in place, and that they are understood and adhered to by their employees.

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[1] A pseudonym allocated by the DHR panel as family did not have a preference.
[2] A pseudonym allocated by the DHR panel as family did not have a preference.
[3] A pseudonym allocated by the DHR panel as family did not have a preference.
[4] A pseudonym allocated by the DHR panel as family did not have a preference.

1.6 **Note:**
It is not the purpose of this DHR to enquire into how George died. That is a matter that has already been examined during Nathan's trial.

2 TIMESCALE

2.1 This review began on 27 September 2018 and the panel met on 5 occasions with the final panel meeting taking place on 13 June 2019. The review was concluded on 5 September 2019 following a ten-week period of consultation with George's family who were supported by AAFDA.

3 CONFIDENTIALITY

3.1 George's family were asked if they wished to nominate pseudonyms to be used in the report but did not indicate a preference. Pseudonyms were therefore identified by the DHR panel. Following consultation George's family were happy with the pseudonyms. These are used in the report to protect the family's identity.

George, Victim.
Nathan, Perpetrator.
Mary, George's wife and Nathan's mother.
Peter, George and Mary's eldest son. Nathan's older brother.

4 TERMS OF REFERENCE

4.1 The purpose of a DHR 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 inform national and local policies and procedures as appropriate;

Prevent domestic violence and homicide and improve service responses for all domestic violence and abuse victims and their children by developing a co-ordinated multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest opportunity;

Contribute to a better understanding of the nature of domestic violence and abuse; and

Highlight good practice.

[Multi Agency Statutory guidance for the conduct of Domestic Homicide Reviews 2016 section 2 paragraph 7]

4.2 Timeframe under Review

The DHR covers the period 1 April 2014 to June 2018.

4.3 Case Specific Terms

Subjects of the DHR
Victim: George 52 years old
Perpetrator: Nathan 27 years old

Terms

1. What indicators of domestic abuse, including coercive and controlling behaviour, did your agency have that could have identified George as a victim of domestic abuse and what was your response.

2. What risk assessments did your agency undertake for the subjects of the review; what was the outcome and if you provided services were they fit for purpose?

3. What was your agency's knowledge of any barriers faced by the subjects of the review that might have prevented them reporting domestic abuse and what did it do to overcome them?

4. What knowledge did your agency have of Nathan's drug and alcohol issues and any mental health needs and what services did you provide?

5. What knowledge or concerns did the victim's family and friends have about the family's victimisation by Nathan and did they know what to do with it?

6. What knowledge did your agency have that indicated Nathan might be a perpetrator of domestic abuse and what was the response, including any referrals to a Multi-Agency Risk Assessment Conference [MARAC] or MAPPA?

7. How did your agency take account of any racial, cultural, linguistic, faith or other diversity issues, when completing assessments and providing services to the subjects of the review?

8. Did your agency follow its domestic abuse policy and procedures, and the multi-agency ones?

9. Did professionals recognise that the conflict in the family amounted to domestic abuse?

10. Were there issues in relation to capacity or resources in your agency that impacted on its ability to provide services to the subjects of the

review, or on your agency's ability to work effectively with other agencies?

11. What learning has emerged for your agency?

12. Are there any examples of outstanding or innovative practice arising from this case? Does the learning in this review appear in other Domestic Homicide Reviews commissioned by Cheshire West and Chester Community Safety Partnership?

13. Does the learning in this review appear in other Domestic Homicide Reviews commissioned by Cheshire West and Chester Community Safety Partnership?

14. To answer questions which George's family may ask.

5 METHODOLOGY

5.1 Following George's murder, a meeting of Cheshire West and Cheshire Community Safety partnership on 25 July 2018 decided that the circumstances met the criteria for a Domestic Homicide Review. The Home Office was informed.

6 INVOLVEMENT OF FAMILY, FRIENDS, WORK COLLEAGUES AND WIDER COMMUNITY

6.1 The Independent Chair and Author have met with Mary who was supported by a member of Advocacy After Fatal Domestic Abuse (AAFDA). They also visited Nathan in prison after he agreed to be seen as part of this process.

6.2 The family were invited to meet the full DHR panel, but they did not wish to do so.

6.3 The Family

6.3.1 George met Mary when he was 18 and she was 16, they had been married for 32 years at the time of his murder. They had three children together.

6.3.2 George was an only child and his parents pre-deceased him. His mother died on 24 May 2018 and her funeral was planned for the morning after George was murdered.

6.3.3 At the time of George's murder their eldest son, lived with George and

Mary in Cheshire West and Chester. Nathan and the couple's daughter had their own accommodation; however, Nathan would spend time at the family home.

6.3.4 Mary described George as a big man, a gentle giant with a really dry sense of humour who loved his family and grandchildren.

6.3.5 Mary described George as a hard-working family man. He worked at a local chemical incineration plant and for many years he worked 12 hour shifts which were 4 days on 6 off which gave them lots of time together.

6.3.6 George and Mary liked cycling together and walking their dogs on New Brighton Beach. George didn't have a big circle of friends but spent time with Mary and their joint friends.

6.3.7 George liked motor bikes and Mary spoke about how he had a "big" bike for many years. She said that he drove a car like "Miss Daisy" but had a "bit of a devil in him" when it came to riding his motorbike. He had sold his last bike about a year before his murder after Mary became concerned about his safety.

6.3.8 Mary described how Nathan as a teenager pushed the boundaries and was asked to leave school due to his poor behaviour. He didn't like rules being imposed on him at school and although being a promising footballer he walked away from a premier league junior team because he didn't like the discipline that was required.

6.3.9 Before the first time Nathan went to prison, he had upset people and owed them money. There were incidents when people came to the house looking for him due to drug debts and windows were broken. Mary could not remember if this was reported to the police. (The police have no records of this).

6.3.10 When Nathan came out of prison for the second time, he was referred to mental health services but didn't go to the appointment.

6.3.11 There was an incident between Nathan and his brother resulting in a restraining order against Nathan whereby Nathan could no longer live in the family home, so Mary sorted out a flat for Nathan. He spent time there, at his sisters and at Mary and George's house. Nathan and his brother got

on eventually, his brother sorted a job as a plasterer, but Nathan lost the job due to not turning up sometimes. On reflection Mary thought that this might have been due to his alcohol consumption.

6.3.12 Mary said that Nathan didn't have friends after he came out of prison and never had an intimate partner as far as his family were aware. He spent time between his flat, his sister's house and Mary/George's house. Mary was well aware of Nathan's drinking issues and recalled that he had been drinking pretty much every day since he had been released from his first prison sentence. He drank cans of beer and bottles of wine. He paid for this from his benefits/wages, but Mary often paid for his rent at his flat.

6.3.13 Mary was supportive of Nathan and attended the hospital with him when he was suffering from perceived mental illness and alcohol related issues.

6.3.14 Mary knew that when Nathan was in hospital, he told the staff that he owed money to drug dealers and that his house had been damaged by these people. She knew that this was either made up or referred to the past when he was about 16. Mary told the chair and author that she tried to tell the medical staff that what Nathan was telling them was untrue and she had not been involved in any risk assessments.

6.3.15 Mary reported she was not involved in the decisions regarding Nathan's care or discharge. She also stated she was not asked whether Nathan could be discharged to her home or recall speaking to any other staff apart from a named Consultant Psychiatrist.

6.3.16 After the first of Nathan's hospital visits in March 2018, the family went on an all-inclusive holiday to Gran Canaria. Mary said that even though Nathan was drinking everyone got on well and they had a lovely holiday.

6.3.17 On the last occasion when Mary took Nathan to A&E she recalled that Nathan was hearing voices telling him to hurt people. Whilst waiting to be seen, Nathan ended up getting agitated and walked out and left. Mary was given 2 tablets for him by the nurse. Mary could not understand why he was allowed to walk out when previous attendances at hospital had resulted in him being detained under section 2 of the Mental Health Act.

6.3.18 Mary articulated three questions that she would like the review to answer. These together with the answers are shown at paragraph 16.13.

6.4 **Nathan**

6.4.1 Nathan agreed to be seen by the Author and Chair. The meeting took place at HMP Garth in the presence of two probation officers.

6.4.2 Nathan stated that he thought he had a normal childhood although he did say that he was expelled from school when he 15. This was for "messing around". It was at this time that he had started drinking alcohol in the form of cans of beer and latterly wine.

6.4.3 At age 16 he briefly had a job in a food factory, but this didn't last long.

6.4.4 Nathan explained when he was 17 he was sent to prison for assaulting another person. When he came out of prison he continued drinking alcohol. He said that he had used cocaine between the age of 15 to 21/22, he never used cannabis just cocaine. He ended up owing drug dealers for the cocaine and because he hadn't paid his parents' house was damaged. Nathan said that his mum ended up paying his debts which were "a couple hundred quid".

6.4.5 Nathan stated that he had gone to prison for a second time for offences of robbery. When he came out of prison his mum sorted out a flat for him in a nearby town. This suited him.

6.4.6 He had a job as a plaster's labourer that his brother found for him but was dismissed for failing to turn up regularly. He then got a job working on a production line at the local Unilever factory. This was agency work and only lasted about a year.

6.4.7 Nathan said that his routine would be to spend a few days at his flat then a couple of days at his sister's then a few days at his mum's. During the day he would start drinking between 3pm and 4pm. He would drink a can of lager or two, a bottle of wine, a couple more cans of lager and another bottle of wine. He would stop drinking between 10pm-12am.

6.4.8 He knew that he had been in hospital but had no recollection of when or what happened. He did state that the stories about using drugs, being in debt and pursued for £10,000 by drug dealers were all made up. He said, "it was reality in my head, but it never happened". The same was also true about his dad and grandad trying to take their own lives.

6.4.9 He said that he had no recollection of the murder of his father.

6.4.10 Nathan appeared to the chair and author of the review to have little insight into his own behaviour. For example, he stated that he had had a 'normal schooling' until he was challenged. He expressed no regret about his situation or remorse for the murder of his father.

6.5 The Independent Chair of the review wrote to George's employer and asked that George's work colleagues and manager be given the opportunity to contribute to the review. No reply was received. This was followed up by a second communication and the Independent Chair was assured that George's colleagues and manager had received the invitation and would respond if they wished to be involved. No communication has been received from them.

7 CONTRIBUTORS TO THE REVIEW / AGENCIES SUBMITTING INDEPENDENT MANAGEMENT REVIEWS (IMRs)

7.1

Agency	Contribution
Cheshire Constabulary	IMR
NHS England West Cheshire Clinical Commissioning Group (CCG)	IMR
Cheshire and Wirral Partnership NHS Foundation Trust (CWP)	IMR
North West Ambulance Service (NWAS)	No information prior to the fatal incident
Countess of Chester Hospital (CoCH)	IMR
National Probation Service (NPS)	IMR
Turning point	Report
Youth Justice Service	IMR

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7.2 As well as the IMRs, each agency provided a chronology of interaction with George, including what decisions were made and what actions were taken. The IMRs considered the Terms of Reference (TOR) and whether internal procedures had been followed and whether, on reflection, they had been adequate. The IMR authors were asked to arrive at a conclusion about what had happened from their own agency's perspective, and to make recommendations where appropriate.

7.3 The IMR should include a comprehensive chronology that charts the involvement of the agency with the victim, perpetrator, and other subjects of the review over the period of time set out in in the 'Terms of Reference' for the review. It should summarise the events that occurred, intelligence and information known to the agency, the decisions reached, the services offered and provided and any other action taken.

7.4 It should also provide an analysis of events that occurred, the decisions made and the actions taken or not taken. Where judgements were made or actions taken that indicate that practice or management could be improved the review should consider not only what happened but why.

7.5 Each homicide may have specific issues that require exploration and each IMR should consider carefully the individual case and how best to structure the review in light of the particular circumstances.

7.6 The IMRs in this case were comprehensive and focussed on the issues facing Nathan. They were quality assured by the original author, the respective agency and by the Panel Chair. Where challenges were made they were responded to promptly and in a spirit of openness and co-operation.

8 THE REVIEW PANEL MEMBERS

Ged McManus	Independent Chair
Mark Wilkie	Support to Chair and Author
Susan Wallace	Detective Constable Cheshire Constabulary
Helen Wormald	NHS West Cheshire Clinical Commissioning Group
Michelle Nicholson	Senior Manager Community Safety Early Help Prevention Service Cheshire West and Chester, (CWac)
Satwinder Lotay	Head of Safeguarding Cheshire and Wirral Partnership NHS Foundation Trust
Zara Woodcock	Senior Manager, Domestic Abuse, Early Help Prevention Service. CWaC [strategic lead within

	CWAC for the prevention/reduction of domestic abuse in CWAC. She is responsible for related operational delivery, including Independent Domestic Violence Advocates, commissioning including refuge provision and abusive partner programs and the children's services Think Family Approach.
Karen Owen	Senior manager, Adult Social Care, Cheshire West and Chester
Alison Kelly	Director of nursing Countess of Chester Hospital NHS Foundation Trust CoCH
Collete Whinnett	Administrator
Tracey King	Operations Manager Turning Point
Katie Makin	Operations Manager Women's Housing Action Group WHAG (Independent DA advisor)
Lisa Jenkins	Senior Operational Support Manager National Probation Service (NPS)
Andrew Rooke	Forhousing

9 AUTHOR OF THE OVERVIEW REPORT

9.1 Ged McManus was chosen as the DHR Independent Chair. He is an independent practitioner who has previously chaired and authored DHR reports and Safeguarding Adult Reviews and was the author of a previous DHR for Cheshire West and Chester. He is currently Independent Chair of a Safeguarding Adult Board in the north of England. He was assisted by Mark Wilkie the report writer who is another independent practitioner and has previously authored DHR reports. Both practitioners served for over thirty years in different police services in England (not Cheshire Constabulary). Neither of them has previously worked for any agency involved in this review.

10 PARALLEL REVIEWS

10.1 An Inquest was opened by the coroner and closed without a hearing after Nathan was found guilty of murder.

10.2 A mental health homicide review has not been commissioned by NHS England at this time. The NHS England Independent Investigations Review Group has considered the case and a decision is pending a review of the Cheshire and Wirral Partnership NHS Foundation Trust IMR and the outcome of the DHR.

There has therefore been no opportunity to conduct a joint mental health/domestic homicide review.

10.3 A DHR should not form part of any disciplinary inquiry or process. Where information emerges during the course of a DHR that indicates disciplinary action may be initiated by a partnership agency, the agency's own disciplinary procedures will be utilised; they should remain separate to the DHR process. (There has been nothing to suggest that a disciplinary inquiry or process is merited in respect of any agency involved in this review).

11 EQUALITY AND DIVERSITY

11.1 Section 4 of the Equality Act 2010 defines protected characteristics as:

- **age** [for example an age group would include "over fifties" or twenty-one year olds. A person aged twenty-one does not share the same characteristic of age with "people in their forties". However, a person aged twenty-one and people in their forties can share the characteristic of being in the "under fifty" age range].
- **disability** [for example a man works in a warehouse, loading and unloading heavy stock. He develops a long-term heart condition and no longer has the ability to lift or move heavy items of stock at work. Lifting and moving such heavy items is not a normal day-to-day activity. However, he is also unable to lift, carry or move moderately heavy everyday objects such as chairs, at work or around the home. This is an adverse effect on a normal day-to-day activity. He is likely to be considered a disabled person for the purposes of the Act].
- **gender reassignment** [for example a person who was born physically female decides to spend the rest of her life as a man. He starts and continues to live as a man. He decides not to seek medical advice as he successfully 'passes' as a man without the need for any medical intervention. He would have the protected characteristic of gender reassignment for the purposes of the Act].
- **marriage and civil partnership** [for example a person who is engaged to be married is not married and therefore does not have this protected characteristic. A divorcee or a person whose civil partnership has been dissolved is not married or in a civil partnership and therefore does not have this protected

characteristic].

- **pregnancy and maternity**
- **race** [for example colour includes being black or white. Nationality includes being a British, Australian or Swiss citizen. Ethnic or national origins include being from a Roma background or of Chinese heritage. A racial group could be "black Britons" which would encompass those people who are both black and who are British citizens].
- **religion or belief** [for example the Baha'i faith, Buddhism, Christianity, Hinduism, Islam, Jainism, Judaism, Rastafarianism, Sikhism and Zoroastrianism are all religions for the purposes of this provision. Beliefs such as humanism and atheism would be beliefs for the purposes of this provision but adherence to a particular football team would not be].
- **sex**
- **sexual orientation** [for example a man who experiences sexual attraction towards both men and women is "bisexual" in terms of sexual orientation even if he has only had relationships with women. A man and a woman who are both attracted only to people of the opposite sex from them share a sexual orientation. A man who is attracted only to other men is a gay man. A woman who is attracted only to other women is a lesbian. So, a gay man and a lesbian share a sexual orientation].

Section 6 of the Act defines 'disability' as:

(1) A person (P) has a disability if:

(a) P has a physical or mental impairment, and

(b) the impairment has a substantial and long-term adverse effect on P's ability to carry out normal day-to-day activities.

11.2 All subjects of the review are white British. At the time of the review they were living in an area which is predominantly of the same demographic and culture. George and Nathan were father and son, they were both heterosexual. They were Christian by upbringing but did not attend Church and their faith was not a big part of their lives. There was nothing within their lives that engaged any of the protected characteristics. There is no evidence arising from the review of any negative or positive bias on the delivery of services to the subjects of the review.

11.3 The Equality Act 2010 [Disability] Regulations 2010 [SI 2010/2128] specifically provide that addiction to alcohol, nicotine or any other substance [except where the addiction originally resulted from the administration of medically prescribed drugs] is to be treated as not amounting to an impairment for the purposes of the Equality Act 2010. Alcohol addiction is not, therefore, covered by the Act.

11.4 The panel recognised that as Domestic Abuse is a gendered crime with women being more likely to be victims than men and that George's murder was a relatively unusual occurrence.

11.5 The Office for National Statistics Homicide report 2017/18[5] shows that 72 females were murdered in domestic homicides whilst 14 men were killed.

12 DISSEMINATION

The Home Office
Cheshire West and Cheshire Community Safety Partnership
Cheshire Constabulary
Cheshire Police and Crime Commissioner
NHS West Cheshire Clinical Commissioning Group
National Probation Service
Cheshire and Wirral Partnership NHS Foundation Trust
Countess of Chester Hospital NHS Foundation Trust
Family members

13 BACKGROUND INFORMATION (THE FACTS)

13.1 George lived with his wife Mary and son Peter at their family home in Cheshire West and Chester. His daughter Natasha had moved out some years ago to live with her partner. Nathan had moved into his own flat in 2013, but would still occasionally stay with the family especially when he needed support.

13.2 On 1 March 2018, Nathan was found on the railway line at Port Sunlight railway station. He was talked off the lines by the Police and detained under Section 136, Mental Health Act, 1983. He was transported to the Royal Liverpool Hospital where he was detained under Section 2, Mental Health Act, 1983 and

5 https://www.ons.gov.uk/.../crimeandjustice/.../homicideinenglandandwales/yearending...

then transferred to Bowmere Hospital (a mental health hospital), which is on the same site as the Countess of Chester Hospital.

13.3 On 6 March 2018, Nathan was discharged from Bowmere Hospital with a diagnosis of Mental & Behavioural disorders due to multiple/psycho active drug use.

13.4 After Nathan's discharge from hospital the family went on an all-inclusive holiday to Gran Canaria. Everyone got on and they had a good time.

13.5 On 11 May 2018, George called Cheshire Constabulary stating that Nathan had put a knife in his dressing gown pocket and that George feared for his safety. The Police attended but could not find a knife. They transported Nathan and his mother to the Countess of Chester Hospital. Nathan was detained under Section 2, Mental Health Act 1983 at Bowmere Hospital but was quickly transferred back to the Countess of Chester Hospital due to being physically unwell. He was treated for chronic liver failure in the Countess of Chester before being returned to the Bowmere hospital for a mental health assessment.

13.6 On 21 May 2018, Nathan was discharged from the Bowmere Hospital after being treated for an Acute Psychotic Episode, Alcohol Withdrawal, Alcohol Dependence Syndrome and Alcoholic Hepatitis: with follow up support from the CHRT and appropriate medication Haloperidol[6].

13.7 On 31 May 2018, Nathan was taken to the Accident and Emergency Department (AED) at the Countess of Chester Hospital by his mother after behaving in an irrational manner. He was seen by a mental health nurse. It was not deemed appropriate to admit Nathan to the Bowmere Hospital, so he left with prescription medication and a follow up plan.

13.8 In early June 2018, Cheshire Constabulary attended at the home address of George. He had been stabbed numerous times to the upper body and head. Nathan was present and was arrested. George was taken to hospital but pronounced dead a short time after arriving.

13.9 Nathan was later charged with the murder of George. He later appeared at Liverpool Crown Court and pleaded not guilty to the charge of murder.

[6] Haloperidol is used in the control of the symptoms of (amongst others) acute psychosis, hyperactivity and aggression.

13.10 On 18 December 2018, at the conclusion of the trial Nathan was found guilty and sentenced to life imprisonment to serve a minimum of 16 years.

14 CHRONOLOGY

14.1 THE FACTS BY AGENCY

14.1.1 Information from the agencies who submitted IMRs is presented without commentary identifying the important points relative to the terms of reference. The main analysis of events appears in Section 16.

14.1.2 To add context to the background story contacts with Agencies prior to the timescales under review are mentioned.

14.2 Prior to the review timeframe

14.2.1 There is no relevant information about the subjects of the review other than Nathan which is detailed. However, in narrative the other subjects do appear because of their interaction with Nathan. All relevant agencies were asked to review their records and provided scoping information prior to requests for more detailed information being made in the form of IMRs. George was not known in his own right to any agency other than his GP prior to the timeframe of the review.

14.2.2 A mental health homicide review has not been commissioned by NHS England at this time. The NHS England Independent Investigations Review Group has considered the case and a decision is pending a review of the Cheshire and Wirral Partnership NHS Foundation Trust IMR and the outcome of the DHR. There has therefore been no opportunity to conduct a joint mental health/domestic homicide review.

14.2.3 Nathan came to the attention of Cheshire Constabulary numerous times for incidents of theft from motor vehicles, theft of motor vehicles, theft from shops (mainly alcohol), criminal damage to motor vehicles, his electronic tag, assaults, breaches of bail and fail to appear warrants.

14.2.4 On 21 April 2006, Mary contacted Cheshire Constabulary regarding her son Nathan alleging that he had taken their vehicle without consent. He was arrested for the offence. This was the start of a lengthy period of offending

14.2.5 In January 2007, a pre-sentence report was prepared by The Cheshire Youth Offending Team, this dealt with a number of offences that Nathan had committed between 21 April 2006 and 21 December 2016. These offences included an assault on a third party, assault on his mother, theft, criminal damage and breach of bail. Nathan did not engage in this process. It was noted in this report that he was using cocaine and drinking alcohol.

14.2.6 On 26 October 2008, he was charged with 5 offences of attempted robbery and possession of an offensive weapon (not domestically related). He was sentenced on 20 January 2009 and was released on licence on 29 November 2010. Whilst in prison Nathan was a victim of an assault which he did not make a formal complaint about. Upon release he was required to reside at Probation Service Approved Premises. During this period Nathan was under the supervision of the then Cheshire Probation Trust.

14.2.7 Between October 2008 and September 2013, Mary made several calls to Cheshire Constabulary about Nathan regarding his criminal conduct and behaviour.

14.2.8 On 10 September 2013, George contacted Cheshire Constabulary stating that his son Nathan had come to the home address, he had been drinking and was making threats against him and his other son, Peter. Police attended and arrested Nathan for the threats and criminal damage to a police vehicle. George did not make a formal complaint, but Peter did and requested a restraining order against his brother. A restraining order against Nathan was issued by West Cheshire Magistrates Court on 26 September 2013, the details of which were as follows: 'You must not contact Peter in any way, by self-servant or agent, also phone, SMS, email or any other means.' The order lasted for 2 years. The then Cheshire Probation Trust had further contact with Nathan in 2013 when a pre-sentence report was prepared in relation to an offence of harassment for which he was sentenced to a Community Order with Unpaid Work.

14.2.9 On 4 November 2013, Nathan started a tenancy agreement for his flat.

14.3 **Within the review timeframe**

14.3.1 On 7 April 2014, Cheshire Constabulary were informed of a theft of lager from a food store. Nathan was identified as the suspect from the CCTV footage and after locating him he agreed to attend for a voluntary interview. Nathan admitted the theft and received a conditional discharge.

14.3.2 Between July and November 2015, there were several contacts between Nathan and Mary with Forhousing. These contacts were generally about rent arrears.

14.3.3 On 1 March 2018, British Transport Police received a call that a suicidal male, Nathan, had been located at Port Sunlight railway station. Nathan was found to be within the tracks but was eventually talked round and he sat in the police car. He stated that he was struggling with his mental health and hearing voices. He admitted to drinking alcohol and taking illegal substances. Nathan also stated that he had been 'kicked out' by his family two days prior because the house had been 'smashed up' due to his drug debt (no record of this) and had been walking round ever since. Nathan was detained under section 136 Mental Health Act and taken to Royal Liverpool University Hospital (RLUH) where he was detained under section 2 Mental Health Act. He was later the same day transferred to the Bowmere Hospital, a local hospital providing a range of psychiatric services situated on the same site as the Countess of Chester Hospital (CoCH).

14.3.4 Nathan was admitted to an acute admission ward (Beech ward) at Bowmere Hospital. On admission Nathan stated he became suicidal whilst drunk and heard a voice telling him to kill himself, he reported that he had previously heard voices but was unwilling to divulge any more information. He stated that he was drinking two bottles of wine and four cans of beer a day.

14.3.5 On 3 March 2018, due to severe agitation and paranoid ideation, Haloperidol[7] & Lorazepam[8] were both administered and accepted orally following a long discussion with nursing staff and on call Senior House Officer.

14.3.6 On 5 March 2018, Nathan was seen by an occupational therapist and stated, that he had been drinking prior to his admission and was having thoughts about being worried about his family which is what caused him to enter the train tracks. He explained that he was now feeling much more settled, had withdrawn from his alcohol use and wanted to stay off it. Nathan stated that he had spoken to his parents so no longer felt worried about this.

14.3.7 On 6 March 2018, Nathan was discharged from Beech Ward with a follow up visit by the Crisis Resolution Mental Health Team (CRHTN) Nurse (CRHTN)

[7] Haloperidol is used in the control of the symptoms of (amongst others) acute psychosis, hyperactivity and aggression.
[8] Lorazepam is used to treat anxiety disorders and alcohol withdrawal

planned for the following day.

14.3.8 On 7 March 2018, CRHT visited Nathan at his parents address. He was seen with Mary present. He denied any thoughts of harm to self or others stating he had reflected upon his admission within the first 24 hours of being on Beech ward. The admission had made him recognise his need to make changes as he did not wish his life to continue revolving around drink which was stopping him from gaining work and endangering his physical health. He identified both short term and long-term positive plans with good family support.

14.3.9 On 20 March 2018, Nathan attended his GP surgery. He presented with anxiety and depression and stated that he had started drinking again. He was prescribed Sertraline[9] and given a not fit for work slip.

14.3.10 On 4 April 2018, Nathan attended his GP surgery. He had not been taking his previously prescribed medication and was still drinking heavily. He was offered a referral to Turning Point, but he stated that he was not ready for that at the moment but would self-refer when ready. Prescribed Citalopram.[10]

14.3.11 On 18 April 2018, Nathan's GP wrote a letter of introduction to Turning Point.

14.3.12 On 10 May 2018, Nathan's mother Mary telephoned the CRHT concerned about Nathan. She described him as going "downhill" with increasing agitation and paranoid thoughts. Nathan had declined to go to hospital, was unwilling to talk to a CRHT nurse on the phone and refused a visit from CRHT. Mary was provided with contact details for the Emergency Duty Team due to the concerns raised by Mary and Nathan's inability to engage.

14.3.13 On 10 May 2018, Mary telephoned Nathan's GP surgery expressing concerns about his mental health.

14.3.14 On 11 May 2018, Cheshire Constabulary were contacted by George who reported that his son Nathan's mental health had deteriorated and he had placed a knife in his dressing gown pocket and that George had concerns for his own safety. Officers attended at the address and established that Nathan did not have a knife in his possession at the time and a decision was made to contact his mother and for them all to take Nathan to the Countess of Chester Hospital (CoCH).

[9] Sertraline is an antidepressant
[10] Citalopram is an antidepressant

14.3.15 Officers transported Nathan and family to the AED, CoCH. Prior to being seen by a Mental Health Nurse, Nathan was seen by the HALs where safe alcohol reduction and a referral to Turning Point is discussed. A Mental Health Nurse at the CoCH reported that Nathan, was having a psychotic episode and his mother was struggling to keep him at the facility. It was reported that security staff were with Nathan but couldn't stay with him and couldn't keep him safe. Police attended and remained with Nathan until he was assessed.

14.3.16 Nathan was seen by a consultant psychiatrist (CP). As the CP assessed that Nathan was suffering from an Acute Psychotic Episode that may be linked to drug misuse a Mental Health Act Assessment was completed and Nathan was detained under Section 2 Mental Health Act. He was transferred to Beech ward at Bowmere Hospital.

14.3.17 On 12 May 2018, Nathan was transferred back to the CoCH AED, accompanied by a staff member from Bowmere, as it was believed that he may have sepsis. He did not want to go as he believed that he could see people by the door who he believed would kill him.

14.3.18 Nathan was initially fully compliant with staff in AED, allowing them to obtain bloods, paranoia appeared to be much reduced, he was interacting appropriately and well with the ward staff escorting him. However, shortly after bloods had been obtained, Nathan proceeded to get up quickly from his chair and walk briskly out from the department. Staff attempted to encourage him to return to the department; however, he ignored them. Ward staff continued to encourage Nathan to return to the waiting area at AED to await blood test results; however, he then ran away from staff, they managed to keep up with him and continued to attempt to de-escalate the situation and encourage Nathan to return but he presented as highly agitated and paranoid, stating to staff, "you're just going to get me there and kill me." Hospital security eventually located ward staff and Nathan, and he was escorted back to AED in holds by security, initially resistive, however this was believed to be more in fear than hostility.

14.3.19 Whilst Nathan was still in AED he was described as, 'currently presenting with overt psychotic symptoms, and responding to unseen stimuli and was presenting as very distressed'.

14.3.20 Nathan was transferred to Ward 49 of the CoCH where he was seen again by the CP and a member of the Hospital Alcohol Liaison (HALS).

14.3.21 On 17 May 2018, Nathan was again seen by a CP. Diagnosis was, Acute Psychotic Episode, Alcohol Withdrawal, Alcohol Dependence Syndrome and Alcoholic Hepatitis.
Risk assessment recorded as:
Given unsettled mental state and his past history he is at risk of harm to self/others.

14.3.22 Just after the consultation Nathan absconded from ward 49, COCH as he felt staff were trying to poison him. He needed to be restrained by security and given rapid tranquilisation.

14.3.23 Later that day Nathan was transferred back to Beech Ward, Bowmere Hospital where he presented in a settled mood.

14.3.24 On 21 May 2018, Nathan was discharged by the CP from Beech Ward. Follow up was to be by the CRHT and a referral to Turning Point. The Clinical Assessment of Risk to Self and Others (CARSO) was updated.

14.3.25 On 22 May 2018, a CRHT nurse attended Mary's home, as scheduled. Nathan was not at the address. Mary stated that he had returned to his flat and had no wish to remain at his mother's. She believed that Nathan would return to drinking and that he had shown no desire to address his alcohol dependence.

14.3.26 The CRHT nurse attended at Nathan's flat but was unable to get a response. The CRHT nurse called Nathan who stated that he had plans today and was somewhat ambivalent to commit to review from CRHT, however he eventually agreed to CRHT making telephone contact the next morning to try and facilitate a time for initial visit.

14.3.27 On 23 May 2018, CRHT nurse attended for a Home Visit at Mary's home address. Nathan stated that he had settled well since his discharge from Beech Ward.

14.3.28 He reported that he had utilised a self-prescribed alcohol plan since being discharged. Prior to admission Nathan had been consuming 2 bottles of wine and 6 cans of lager on a daily basis. He stated that he had developed this drinking pattern as a means of self-medication to both induce sleep and subdue auditory hallucinations. Nathan described hearing voices for many years and described a singular male external voice that provided a running commentary on his actions.

14.3.29 Since discharge Nathan had resumed drinking again, though he recognised the adverse impact this has had on his mental and physical health and expressed motivation in addressing his dependence. He stated that it was never within his compass to go 'cold turkey' and he had therefore established a plan whereby he now refrained from consuming wine and instead only consumed 6 cans of normal strength lager with the idea of slowly reducing with support of Turning Point. He denied any use of psychoactive substances

14.3.30 Nathan stated that he intended to engage with Turning Point in the near future, but not immediately, as he initially wished to recover from his recent relapse and taper down slowly of his own accord.

14.3.31 On 23 May 2018, at a meeting between CRHT and Early Intervention Team (EIT) it was agreed that provided Nathan had not previously accessed treatment for psychosis (it appears he was referred to EIT in 2010 however did not engage), an initial assessment was warranted. Nathan was to be offered an assessment on 31 May 2018.

14.3.32 On 24 May 2018, EIT requested support from CRHT in contacting Nathan to arrange an appointment for an initial assessment.

14.3.33 On 24 May 2018, EIT attempted contact by telephone with Nathan using a mobile number provided by CRHT. No answer, therefore a letter was to be sent offering an appointment for an initial assessment with EIT on 31 May 2018, at 11 am at Mary's home address.

14.3.34 On 25 May 2018, CRHT contacted Nathan to arrange a home visit. Nathan reported that his Nan had died yesterday and that the family were currently grieving. Condolences were offered to Nathan. He was reassured that support was available 24/7, Nathan thanked the CRHT nurse for the support and gave assurances that he would reach out if he felt he needed the support.

14.3.35 Nathan was encouraged to answer calls from withheld numbers as they would more than likely be from CWP practitioners. Nathan declined the offer of a visit that day, arrangements were made for EIT to contact him the following day to arrange a face to face visit, Nathan was happy with that.

14.3.36 On 25 May 2018, CRHT nurse contacted EIT to confirm that Nathan is happy with planned contact from EIT on 31 May 2018.

14.3.37 On 25 May 2018, Nathan telephoned his GP surgery asking for a not fit for work

slip which was issued.

14.3.38 Between 26-30 May 2018, numerous attempts were made by the CRHT to contact Nathan, including a failed visit to his address.

14.3.39 On 30 May 2018, Mary contacted the EIT stating Nathan had returned to stay at his own address. She also mentioned that she did not believe that Nathan would engage with services.

14.3.40 On 30 May 2018, Mary telephoned the CRHT. She stated she had an argument with Nathan following his refusal to change his behaviour (drinking etcetera), and that he had returned to his own flat.

14.3.41 On 31 May 2018, an EIT meeting took place. A decision was made to rearrange the planned assessment appointment due to concerns around risk in terms of seeing Nathan at home given his substance use and forensic history.

14.3.42 On 31 May 2018, EIT staff attended Nathan's home address to provide him with a letter for a further appointment on 08 June 2018 at the Cherrybank Resource Centre. Nathan wasn't in but a letter was left.

14.3.43 On 31 May 2018, telephone contact from Mary to CRHT. She stated that Nathan was 'kicking off' and getting aggressive and hearing voices and asked if CRHT could respond. CRHT were unable to respond. Nathan's mother stated she would take Nathan to AED at the CoCH.

14.3.44 On 31 May 2018, Nathan was seen by a Mental Health Nurse in the AED, CoCH. Nathan was not willing to engage in the assessment and stated he wanted a few days in Bowmere. The previous admission was discussed and it was agreed it was not helpful because Nathan had not addressed his alcohol issues. It was agreed that Nathan needed to engage with the CRHT and EIT. CRHT would visit him in the morning to discuss support. A Mental Health Nurse spoke to Mary as Nathan left AED.

14.3.45 On 1 June 2018, failed home visit by CRHT to Nathan.

14.3.46 On 1 June 2018, Nathan failed to attend an initial assessment with Turning Point.

14.3.47 On 2 June 2018, CRHT contacted Nathan, he was pleasant, stated he felt good, but he was annoyed as the visit planned for the previous day was hours

late, so in the end he went out. He stated he felt well and reported no problems, he requested no visits at the weekend as he had plans, but agreed to a home visit on Monday 4 June 2018, at 11:00 prompt.

14.3.48 On 4 June 2018, CRHT attended at Nathan's address for the arranged meeting. He was not there. No answer on his mobile so a message was left.

14.3.49 On 4 June 2018, Nathan failed to attend an initial assessment with Turning Point.

14.3.50 On 5 June 2018, there were two failed home visits by CRHT to Nathan. Contact made with his parents.

14.3.51 On 5 June 2018, failed telephone contact by the EIT to Nathan.

14.3.52 On 6 June 2018, CRHT telephoned Nathan, no answer. They then visited his address but could not contact him. A letter was left with a neighbour, as CRHT could not access his letter box, who agreed to post it through Nathan's door.

14.3.53 On 8 June 2018, Nathan failed to attend the arranged meeting with EIT. CRHT were informed.

14.3.54 On 8 June 2018, CRHT visited Nathan's address but could not contact him. Nathan's parents were spoken to and agreed to ask Nathan to contact CRHT.

14.3.55 On 11 June 2018, EIT attempted to contact Nathan by phone. There was no answer.

14.3.56 On 12 June 2018, EIT attempted to contact Nathan's parents by phone. There was no answer and it was not possible to leave a message.

14.3.57 On [redacted] 2018, critical incident leading to the investigation and charging of Nathan with the murder of George.

15 OVERVIEW

15.1 This overview has been compiled from analysis of the multi-agency chronology, the information supplied in the IMRs and supplementary reports from some agencies. Information from police statements has also been used. Findings from previous reviews and research into various aspects of domestic abuse has been considered.

15.2 In preparing the overview report the following documents were referred to:

- The Home Office multi-agency Statutory Guidance for the conduct of Domestic Homicide reviews 2016
- The Home Office Domestic Homicide Review Tool Kit Guide for Overview Report Writers
- Home Office Domestic Homicide Reviews – Common themes identified and lessons learned – November 2013
- Key findings from analysis of Domestic Homicide Reviews. Home Office December 2016
- Agency IMRs and Chronologies

15.3 **Nathan**

15.3.1 Nathan had a difficult adolescence, suffering problems at school and with the Police. He lived with his mother, father, brother and sister and started abusing alcohol and cocaine.

15.3.2 Nathan came to the attention of Cheshire Constabulary numerous times for incidents of theft from motor vehicles, theft of motor vehicles, theft from shops (mainly alcohol), criminal damage to motor vehicles, his electronic tag, assaults, breaches of bail and fail to appear warrants.

15.3.3 On 26 October 2008, he was charged with several offences of attempted robbery and possession of an offensive weapon (not domestically related). He was sentenced on 20 January 2009 to 4 years imprisonment and was released on licence on 29 November 2010. Nathan reported being a victim of an assault whilst in prison but did not make a formal complaint about that.

15.3.4 On release from prison as part of his licence conditions Nathan had to reside at Probation Service Approved Premises such were the concerns about his behaviour in the family home. He was however, eventually allowed to return.

15.3.5 On 10 September 2013, Nathan was arrested for making threats towards his brother Peter and dad George at their home address. He also damaged a Police vehicle. George did not make a formal complaint but Peter did and

requested a restraining order against Nathan. A restraining order against Nathan was issued by West Cheshire Magistrates Court on 26 September 2013. The order lasted until 25 September 2015. Pre-sentence reports were prepared by the then Cheshire Probation Trust.

15.3.6 In November 2013, Nathan took up a tenancy of a flat provided by Forhousing. This is 7 miles away from the family home.

15.3.7 Nathan had worked at a sandwich factory and as a plasterer but had difficulty maintaining employment because of his drinking. He also worked at Unilever in Port Sunlight some time before killing his father.

15.3.8 On 1 March 2018, Nathan was found by British Transport Police at Port Sunlight railway station. He was found to be within the tracks but was eventually talked off the tracks by the police. He stated that he was struggling with his mental health and hearing voices. He admitted to drinking alcohol and taking illegal substances. Nathan also stated that he had been 'kicked out' by his family two days prior because the house had been 'smashed up' due to his drug debt (no record of this) and had been walking round ever since. He was detained under section 136 Mental Health Act and taken to Liverpool Royal Liverpool University Hospital (RLUH) where he was later detained under section 2 Mental Health Act. He was later transferred to the Bowmere Hospital.

15.3.9 Nathan spent four days on Beech Ward, Bowmere Hospital, CoCH. During this time, he was given rapid tranquilisation due to severe agitation and paranoid ideation. He disclosed that he had been drinking 2 bottles of wine and 4 cans of beer a day but wanted to try and stay off alcohol.

15.3.10 Nathan was further involved with mental health services which in general he did not engage with. Although he had his own home he continued to spend time at his parents. In depth of these engagements is give in Section14 the chronology.

15.3.11 In June 2018, Nathan was arrested on suspicion of the murder of George.

15.3.12 On 18 December 2018, after being found guilty of the murder Nathan was sentenced to life imprisonment with a minimum term of 16 years.

15.3.13 Sentencing him, Judge Clement Goldstone QC, the Recorder of Liverpool, said: "The jury rejected medical evidence called on your behalf to the effect that you were suffering from schizophrenia, to alleviate the symptoms of which you consumed copious amounts of alcohol, and concluded instead that the

psychotic symptoms from which you suffered were caused by your heavy consumption of alcohol over a prolonged period in which you chose to indulge, despite the fact that you were aware of and had good insight into the effect of such drinking habits upon your physical and mental health.

On [redacted], you spent the evening at your parents' home much like you spent many other evenings - drinking.

You may also have been taking cocaine, but I cannot be sure of your drug-taking habits in general, or indeed whether you were affected by cocaine on the night in question.

Shortly after midnight, whilst your father was asleep in a chair you attacked him with two knives, stabbing him no fewer than 19 times – why you did so, none of us will ever know – and you yourself may never know.

There was no obvious sign of hostility between the two of you and it would be idle speculation to suggest that this attack had anything to do with the fact that your father had called the emergency services over a month earlier because you were brandishing one of the knives with which you later stabbed him.

There is no reason to believe that, had you not been suffering from alcohol induced psychosis, you would have stabbed him – but stab him you did, and there was never any suggestion that you were so drunk that you were at the material time incapable of forming the intent either "Indeed, the evidence of your mother and brother who saw you and your father in the immediate aftermath of your attack upon him, together with the police and medical services who attended soon after, paint a picture of eerie calmness and detachment from reality.

What we do know is that as a result of killing your father, you have left your mother, brother and sister utterly distraught and their lives are devastated.

George's grandchildren will never get to know or appreciate the true quality of the man who was their grandfather.

Your mother and father never stopped loving and caring for you and made every allowance for your problems in the 10 years or so since they first manifested themselves

There is no reason to believe that, had you not been suffering from alcohol

induced psychosis, you would have stabbed him – but stab him you did, and there was never any suggestion that you were so drunk that you were at the material time incapable of forming the intent either to kill him or to cause him really serious injury.

But you were, certainly in the months leading up to the murder of your father, unwilling to break or even reduce your voluntary dependency upon alcohol, nor even to remain compliant with medication which had been prescribed.

16 ANALYSIS

Each term appears in bold and is examined separately. Commentary is made using material in the IMRs and the DHR Panel's debates. Some material would fit into more than one term and where that happens a best fit approach has been taken.

16.1 What indicators of domestic abuse, including coercive and controlling behaviour, did your agency have that could have identified George as a victim of domestic abuse and what was your response?

16.1.1 During the time frame under review there was no domestic abuse or controlling behaviour identified by Cheshire Constabulary which identified George as a victim.

16.1.2 There is an indication from the incident on 7 April 2013, which shows George to be very frustrated by his son's behaviour, resulting in him becoming aggressive with officers, throwing items and eventually demanding officers leave his premises.

16.1.3 There were historic domestic incidents, as previously outlined and it is of note that George only featured as a reporting person on two occasions. One of the incidents was pre-terms of reference (10 September 2013), whereby he contacted police to say that he and Peter had been threatened by Nathan. George did not make a formal complaint, but Peter did and a restraining order was issued by the court.

16.1.4 The Countess of Chester Hospital (CoCH) did not identify any indicators of domestic abuse. On the two occasions that Nathan attended there were no indicators in those attendances to prompt them to ask about domestic abuse.

16.1.5 The CWP chronology had highlighted there were occasions where practitioners had been informed of risk concerns and also risk incidents to suggest George and family could have been at increased risk of harm from Nathan.

16.1.6 On 1 March 2018, Nathan reported to mental health practitioners that George's and his sister's property had been damaged by drug associates due to Nathan's drug debts. The panel now know that this was untrue and that Nathan's family were never asked about this information.

16.1.7 The section papers dated 2 March 2018, stated that Nathan had reported to experience voices in his head to kill himself or someone else (these were not specific to George or any other named individual) when he was intoxicated, but denied any current risks of harm to self or towards others at the time of the mental health assessment.

16.1.8 On 3 March 2018, Nathan became increasingly agitated on the ward and threatened to use objects from the ward environment as a weapon to stab people, he stated that he has stabbed people in the past. A pre-sentence report in Nathan's paper records highlighted previous arrests for Section 47 assault on 21 April 2006 following an unprovoked attack on a young person using a glass beer bottle as a weapon and a Section 39 assault on 11 December 2006. This information was not known to the clinical staff at the time.

16.1.9 At the time of Nathan's first admission to Beech ward on 2 March 2018, the CARSO[11] and clinical records identify that Nathan had claimed that George had attempted to take his own life by hanging 4 days earlier, prompted by George's father attempting to take his own life. However, the SHO recorded that Nathan appeared to be confused about the reasons for his Father and Grandfather to attempt to take their own lives. The clinical records indicate that this was not explored further with Nathan or his family during his inpatient stay.

16.1.10 During his medical review on 5 March 2018 with a psychiatrist, Nathan stated that he had been consuming a lot of alcohol and had not been speaking to Mary, which Nathan identified as a precipitating factor to his most recent risk-taking behaviour. Nathan informed the psychiatrist that George and Mary had requested him to stay with them so they could support his recovery following his

[11] Clinical Assessment of Risk to Self and Others

discharge. However, there is no information in the clinical records to show mental health professionals discussed Nathan's discharge plan or risk assessment with his parents.

16.1.11 Following Nathan's mental health assessment on 11 May 2018, a Mental Health Nurse updated the CARSO and documented the above concerns but, there was no indication in the clinical records to suggest the alleged attempts to take their own lives by George and his Father were explored with Mary or Nathan at the time of the assessment, or by other practitioners during his second inpatient stay prior to his discharge to CRHT and EIT.

16.1.12 On 11 May 2018, it was documented in the mental health assessment that George had contacted the Police to report Nathan was at their address behaving in a paranoid and suspicious manner. The Police had been informed that Nathan had obtained a knife from their home. It is documented in the records that Mary had reported to a Mental Health Nurse "you don't know the half of it". The panel discussed whether this comment should have been explored further however in the context of a busy AED the panel accepted that this was not always possible.

16.1.13 On 30 May 2018, Mary contacted the CRHT and informed them that Nathan had returned to his own property following an argument about his alcohol use and reported he is not accessing support from alcohol services.

16.1.14 On 31 May 2018, Mary telephoned CRHT and informed them that Nathan was hearing voices, "kicking off" and becoming aggressive. Mary informed them that she was going to take Nathan to AED. Later the same day Nathan attended AED, COCH, accompanied by Mary. Due to threats of self-harm and hearing voices he was seen by a Mental Health Nurse from Liaison Psychiatry. Mary was seen separately by a Mental Health Nurse but there was no indication in the records to suggest Mary had raised any concerns to suggest there was any domestic abuse towards her or George. Mary does not recall being asked about domestic abuse.

16.1.15 The clinical records indicate that practitioners did not have any direct contact with George during Nathan's involvement with CWP adult mental health services and, clinical records suggest practitioners relied on Mary's views only regarding Nathan's risk behaviours when intoxicated and did not consider George's views or wishes regarding Nathan's alcohol use and the potential impact on family relationships.

16.1.16 There were no indicators of domestic abuse, including coercive and controlling behaviour, identified or reported to the GP practice.

16.1.17 The panel considered whether there was evidence that Nathan had subjected George or his family to coercion and control and in doing so referred to the Crown Prosecution Service policy guidance.

16.1.18 The Crown Prosecution Service policy guidance on coercive control states[12];

Building on examples within the Statutory Guidance, relevant behaviour of the perpetrator can include:

- Isolating a person from their friends and family
- Depriving them of their basic needs
- Monitoring their time
- Monitoring a person via online communication tools or using spyware
- Taking control over aspects of their everyday life, such as where they can go, who they can see, what to wear and when they can sleep
- Depriving them access to support services, such as specialist support or medical services
- Repeatedly putting them down such as telling them they are worthless
- Enforcing rules and activity which humiliate, degrade or dehumanise the victim
- Forcing the victim to take part in criminal activity such as shoplifting, neglect or abuse of children to encourage self-blame and prevent disclosure to authorities
- Financial abuse including control of finances, such as only allowing a person a punitive allowance
- Control ability to go to school or place of study
- Taking wages, benefits or allowances
- Threats to hurt or kill
- Threats to harm a child
- Threats to reveal or publish private information (e.g. threatening to 'out' someone)

[12] www.cps.gov.uk/legal-guidance/controlling-or-coercive-behaviour-intimate-or-family-relationship

- Threats to hurt or physically harming a family pet
- Assault
- Criminal damage (such as destruction of household goods)
- Preventing a person from having access to transport or from working
- Preventing a person from being able to attend school, college or University
- Family 'dishonour'
- Reputational damage
- Disclosure of sexual orientation
- Disclosure of HIV status or other medical condition without consent
- Limiting access to family, friends and finances

This is not an exhaustive list and prosecutors should be aware that a perpetrator will often tailor the conduct to the victim, and that this conduct can vary to a high degree from one person to the next.

16.1.19 The panel discussed Nathan's behaviour and saw that he had historically threatened and assaulted his parents and stolen their property. It is clear that they were supporting him financially, for example by paying his rent when he spent his own money on alcohol. However, the panel felt that there was insufficient information to conclude that Nathan had exhibited coercive and controlling behaviour.

16.1.20 The panel recognised that some of Nathan's behaviours could be seen in the context of adolescent to parent violence (APVA), albeit that Nathan was beyond adolescence. An extract from The Home Office information on APVA states[13];

'APVA and the pathways appear to be complex. Some families experiencing APVA have a history of domestic violence and abuse. In other cases, the violence is contextualised with other behavioural problems, substance abuse, mental health problems, learning difficulties, or self-harm. In some cases, there are no apparent explanations for the violence and some parents find it difficult to understand why one child is aggressive towards them when their other children do not display such behaviour'

16.1.21 Kathleen M Heide PHD is professor of criminology at the University of South

[13] http://safelives.org.uk/sites/default/files/resources/HO%20Information%20APVA.pdf

Florida, Tampa. She has published two widely acclaimed books on juvenile homicide, her book, "Understanding Parricide: When Sons and Daughters Kill Parents" published by Oxford University Press in November 2012 states, that most cases can be categorized into three primary types of parricide offenders: the severely abused child, the dangerously antisocial child, and the severely mentally ill child. Among children, adolescents, and young adults, the severely abused child and the dangerously antisocial child are most common. Among older adults, the severely mentally ill and the dangerously antisocial types predominate.

- Severely abused children (SAC) kill their abusive parent to end the abuse. These individuals have been abused by their parent(s) for years. The abuse is typically known to others. SAC have sought help from others and, yet, the abuse has continued. They often have tried to run away, considered suicide, and, in some cases, have attempted to kill themselves. Over time, the violence in the home escalates and these individuals become increasingly stressed. They kill the abusive parent because they are terrified that they or other family members will be seriously harmed or killed. They are typically desperate and see no other way out but murder. These individuals typically have a longstanding history of depression and meet the diagnostic criteria for Post-traumatic Stress Disorder (PTSD).
- Dangerously antisocial children (DAC) kill the parent to further their own goals. In these cases, the parent is an obstacle in their path to getting what they want. These individuals, for example, may kill to have more freedom, to continue dating a person to whom the parents object, and to inherit money they believe is eventually coming to them. DAC have a pattern of violating the rights of others when it suits them. Typically, this behavioural pattern begins in childhood. Youths who continuously defy adults, do what they want on their own timeframe, and do not accept responsibility for their actions over a significant period of time will likely be diagnosed as having Oppositional Defiant Disorder. If this behavioural pattern is not corrected, the youth often will engage in criminal activities that may include violence towards people or animals, destruction of property, deceitfulness or theft, and/or serious violations of rules by parents, such as staying out all night or being truant from school. At this point, the youth will likely be diagnosed as having a Conduct Disorder. If this pattern of violating the rights of others continues past age 18, it is likely that this individual may be diagnosed as having an Antisocial Personality Disorder. This type of parricide offender is far more dangerous to society than the first in terms of re-offending and hurting other people in the future.

- Severely mentally ill children (SMIC) kill the parent largely as a result of severe mental illness. Diagnoses commonly made include psychosis and severe depression. A longstanding history of mental illness is generally easy to document in these cases. SMIC are typically on psychotropic medication and are most apt to kill when they stop taking it. They may kill the parent, for example, because they have delusions (bizarre and irrational beliefs) that the parent is the devil. They may report hearing God's voice commanding them (an hallucination -- false sensory experience) to kill the parent.

16.1.22 Nathan does not fit directly into one of the three categorises but demonstrated some characteristics of the DAC and SMIC, highlighting that this is an unusual case.

16.2 **What risk assessments did your agency undertake for the subjects of the review; what was the outcome and if you provided services were they fit for purpose?**

16.2.1 Cheshire Constabulary attended one incident at the family home during the period under review. Nathan was taken to hospital where he received appropriate treatment. A Vulnerable Person Assessment (VPA), the purpose of which is to alert partner agencies to a vulnerable persons' needs was not submitted as Nathan was receiving appropriate treatment from partner agencies at the hospital. This complied with Cheshire Constabulary policy. However, information provided by George during the incident identified that he was concerned for his own safety, this should have resulted in a VPA and DASH[14] risk assessment being completed and this did not happen. This is discussed in more detail at paragraph 16.9.4.

16.2.2 The CoCH did not complete any Domestic Abuse Risk Assessments in this case because Domestic Abuse was not identified as an issue during any contacts with family members. CoCH staff ensured as appropriate that the Mental Health Team were present to assess Nathan in the AED on each occasion he was seen as per CoCH-Cheshire & Wirral Partnership NHS Foundation Trust (CWP) mental health pathways.

16.2.3 CWP records indicated that a number of risk screening tools, including CARSO, HoNoS[15] and AUDIT[16] were utilised to collect detailed information about

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[14] Domestic Abuse, Stalking and Honour Based Violence risk identification used by the police.
[15] HoNoS measures the symptom severity and social functioning across time. It has twelve items that measure behaviour impairment and social functioning

Nathan's clinical history and current presentation to identify Nathan's risk of harm to himself, towards others and from others to support practitioners to make clinical decisions in relation to the above risk indicators, these are detailed within this section.

16.2.4 On 2 March 2018, Nathan was assessed by RLUH mental health professionals and was formally detained under Section 2 MHA before being transported to Beech ward, Bowmere Hospital, to enable mental health professionals to further assess his mental health due to his current increased risks of harm to self and suicidal behaviours. During his admission onto Beech Ward, the records indicate attempts to explore the concern around Nathan's disclosure about his Grandfather and George's recent attempts to take their own lives. Records showed that Nathan appeared to be confused about the reasons for both attempts. (There were no attempts to take their own lives).

16.2.5 On 3 March 2018, Nathan became increasingly agitated on the ward and threatened to use objects from the ward environment as a weapon to stab people, he stated that he had stabbed people in the past. The clinical records indicate that practitioners managed the risk safely and effectively to ensure there was no further risk of harm to himself or others on the ward; this appears to be reflected in the clinical records during this first admission as there are no further incidents reported as a 'risk event'.

16.2.6 On 4 March 2018, it was documented that there was a discussion of the reasons for admission with Nathan, including attempts by his father and grandfather to take their own lives, but there is no record of this being considered as part of his risk management or discharge plan. There is no evidence that Nathan's family were contacted to discuss the alleged suicide risk prior to his discharge to their address. This would have been an opportunity for practitioners to obtain additional information from Nathan's parents about suicide risks and potential stressors on family relationships and the home environment.

16.2.7 The CWP chronology indicates that a CARSO was completed on 3 March 2018, 11 May 2018, 12 May 2018 and 21 May 2018. The risk of 'harm to others' identifies that Nathan had reported that he hears a voice telling him to harm others, as well as historical forensic history which includes burglary, aggravated burglary theft, armed robbery, criminal damage and driving without consent, but

[16] The AUDIT screening (Alcohol Use Disorders Identification Test) is a 10-item screening tool developed by the World Health Organization (WHO) to assess alcohol consumption, drinking behaviours, and alcohol-related problems

a previous conviction for assaulting a Police Officer and possession of weapons, documented on 1 March 2018 is not included in the CARSO. The records indicated that the CARSO was not updated following Nathan's threats to stab someone on 3 March 2018, whilst an inpatient on Beech Ward under 'risk of harm towards others.'

16.2.8 The CARSO completed on 11 May 2018, highlights the risk under the heading 'harm to others' relating to Nathan secreting a knife up his sleeve prior to being assessed by Liaison Psychiatry, as well as the previous alleged attempts by Nathan's Grandfather and George to take their own lives under the heading of 'risk to self'. However, the CARSO dated 12 May 2018 and 21 May 2018, does not include the alleged attempts on life and there is no evidence in the records to indicate that this was followed up by practitioners during his second admission to Beech ward or, that the concerns were discussed with Nathan's family prior to his discharge to CRHT and EIT.

16.2.9 The 'risk of harm from others' identifies Nathan and his family as a victim of increased violence from drug associates in all of the CARSOs but, there is no indication in the records that practitioners explored this further with Nathan or family members to ascertain the level of risk, as well as establishing if the incidents had been reported to the Police.

16.2.10 A number of mitigating factors were identified throughout the records to support Nathan's care and risk management plan and included a comprehensive summary of all relevant risks identified in his mental health assessment completed on 2 March 2018, and on 3 March 2018, when he was admitted to Beech ward. However, there is no evidence in the chronology to suggest that practitioners explored Nathan's feelings of paranoia around his disclosure that Mary was no longer speaking to him. This was another opportunity for practitioners to gain a better understanding of the relationship dynamics within the family environment and identify any potential domestic abuse triggers due to Nathan's alcohol and illicit substance use.

16.2.11 An AUDIT questionnaire was completed with Nathan on 2 March 2018 and on 11 May 2018. The CARSO reflects the risk of harm to self and others due to his current alcohol use and that Nathan was reported to be using 1 gram of cocaine 3-4 times per week and also his concerns about risk of harm from others due to the reported debt of £10 000 to dealers, and as a result of the debt his parents' property had been damaged. However, there is no evidence in the records to indicate that the concerns were discussed with Nathan's family to establish how the threat of harm from others impacted on Nathan's mood and

risk-taking behaviour. Nathan reported to practitioners that his suicidal thoughts were often triggered around his worries that he had for his family but there is no evidence in the records to indicate that practitioners considered what his concerns were about or if his suicidal behaviours impacted on family relationships as part of his risk management plan.

16.2.12 The CARSO was reviewed by CRHT as part of discharge planning on 6 March 2018; a number of mitigating factors are recorded in respect of Nathan as follows:
Nathan was planning to seek support from community services for his alcohol use following his discharge from Beech ward.
Nathan was planning to stay with his parents to continue his recovery.
Nathan did not believe that he was a risk to himself.
Nathan had agreed to a home visit from the Crisis Home Treatment Team as part of a 7-day follow-up at his parents' address.

16.2.13 The overall summary of risk at the point of discharge was:

Alcohol dependent
History of illicit substance use
Poor engagement with adult mental health services
Increased risk of harm to self and towards others when intoxicated.
Financial debt
Risk of harm from others

16.2.14 On 7 March 2018, CRHT attended at Mary and George's address where Nathan was currently staying as a routine CRHT home visit appointment. The records indicate that Nathan was not experiencing any thoughts of harm to self or others, stating the admission had provided him with an opportunity to reflect on his risk-taking behaviours, including his alcohol use acknowledging the impact alcohol was having on his physical and mental health and wellbeing. It is documented that Nathan declined any further support from CRHT and there was no evidence in the records to indicate that there were any increased risks. CRHT informed a CP that both Nathan and Mary mutually agreed to Nathan being discharged from CRHT and both stated they were happy to contact the relevant teams in the event of an emergency or crisis in relation to Nathan's mental health.

16.2.15 On 11 May 2018, Nathan was assessed by Liaison Psychiatry after being taken to AED by Police under section 136 (MHA). Nathan was detained under Section 2, MHA and transferred to Beech ward, Bowmere Hospital later that

same evening. Shortly afterwards he was transported back to, COCH due to his acute physical health needs where he was treated until 17 May 2018. He also had a member of staff from Beech ward with him who provided 24 hour one to one support.

16.2.16 On 21 May 2018, Nathan was reviewed by a CP and discharge planning was discussed with Nathan following his mental health status being regraded to an informal patient. The records indicate that Nathan's risks around harm and suicide were minimal, the CP documented that Nathan had capacity and is willing to engage with CRHT if he is discharged on 21 May 2018. The following plan was mutually agreed by Nathan and the CP;

Nathan to be followed up by CRHT.

Continue with current prescribed medication - Thiamine[17] and Haloperidol.

Physical health needs to be followed up.

Nathan to self-refer to Turning Point to help him to abstain from alcohol.

16.2.17 On 22 May 2018, CRHT attended Mary and George's address. Nathan had returned to his own address and had no wish to stay with them. Mary believed that Nathan would not engage with services and may relapse with alcohol. Nathan agreed to a telephone call from CRHT on 23 May 2018, to arrange a further home visit.

16.2.18 Nathan was seen by CRHT at his parents address on 23 May 2018. Nathan was observed to not be exhibiting any overt psychotic features and no current risks were identified although, it was acknowledged by Nathan that his alcohol use could escalate his risk behaviours. CRHT told a CP that they did not observe any behaviour from Nathan to suggest that there was any evident risk of harm to self or others. Nathan agreed to CRHT making telephone contact on 24 May 2018 to arrange a home visit.

16.2.19 On 24 May 2018, EIT discussed Nathan's referral at the Multi-Disciplinary Team meeting. An initial assessment appointment was arranged for 31 May 2018. EIT contacted CRHT to request their support to encourage Nathan to attend the initial appointment at Mary and George's home or an alternative venue if Nathan would prefer. The records indicate that an appointment letter was sent out to Nathan by EIT and further attempts were made to contact Nathan via his mobile, Mary and George's home telephone and Nathan's home address.

16.2.20 It was evident in the records that CRHT were also experiencing difficulties with attempts to contact Nathan via his mobile as well as locating him at his or his

[17] Thiamine is commonly known as vitamin B

parent's home address.

16.2.21 On 24 May 2018, CRHT informed Nathan about his arranged appointment with EIT and he was agreeable to attending.

16.2.22 On 26 May 2018, CRHT have a failed telephone contact with Nathan. Further attempts were made by CRHT and EIT to contact Nathan on 27 May 2018 and 29 May 2018 to assess his wellbeing and arrange a home visit. An unannounced call was made by CRHT to Nathan's home address without any success.

16.2.23 On 30 May 2018, Mary contacted the CRHT and informed them that Nathan had returned to his own property following an argument about his alcohol use and reported that Nathan was not currently accessing support from alcohol services.

16.2.24 CRHT and EIT practitioners made a significant number of attempts to contact both Nathan and his parents both face to face and via telephone without success. They made a concerted effort to engage with Nathan.

16.2.25 It is a significant feature of Nathan's interaction with medical professionals that little or nothing was done to confirm the information that he gave to them. We now know that Nathan reported he was not taking drugs, there were no outstanding debts to drug dealers and no damage to the family home; at least in recent years. Nathan's grandfather and father had not attempted to take their own lives. Professionals could have attempted to confirm the information that Nathan gave them through his family, the police or drug screening. The panel heard from the CWP representative that the additional information may have changed the understanding of Nathan's level of psychosis but it would not have changed the care and treatment plan; it is also uncertain as to whether it would have changed the risk assessments that were completed.

16.3 What was your agency's knowledge of any barriers faced by the subjects of the review that might have prevented them reporting domestic abuse and what did it do to overcome them?

16.3.1 No barriers have been identified by Cheshire Constabulary during the period under review for failure to report domestic incidents. It is of note that Mary did contact police to report her son for many and varied reasons including damage, theft and breach of bail. George also reported his son on two occasions and Nathan's brother Peter also instigated a restraining order.

16.3.2 CWP clinical records showed that practitioners did speak to Mary on a number of occasions (Mary only recalls being spoken to twice). This would have enabled Mary to raise or report domestic abuse concerns from Nathan towards George or herself.

16.3.3 The staff in the CoCH AED are trained in considering and responding to domestic abuse. There have been many cases where mental health has been the presenting complaint, but domestic abuse has been suspected and as well as the presenting complaint being addressed the Domestic Abuse policy has also been followed. However, the IMR of the records for this case has not highlighted any documented evidence that could indicate that staff should have considered that Nathan was a perpetrator of Domestic Abuse, rather the case was responded to as a serious mental health deterioration in Nathan and the correct response to this presentation was initiated. There is nothing in the records to suggest that staff could have identified barriers faced by the subjects of the review in disclosing Domestic Abuse, if Domestic Abuse had been suspected, staff would have been expected to consider this when safe to do so and to follow the CoCH Domestic Abuse Policy.

16.3.4 There are a number of surveys which outline why victim's may not report abuse. The Victim Support report 'Surviving justice' 2017 report contains the following information.

Barriers to reporting as cited by Victim Support Caseworkers

Barriers to reporting	Percentage of respondents citing barrier
Pressure from perpetrator, fear of perpetrator, belief that they would be in more danger	52%
Fear they would not be believed or taken seriously	42%
Fear, dislike or distrust of the police/CJS	25%
Concern about their children and/or the involvement of social services	23%
Poor previous experience of police/CJS	22%
Abuse normalised, not understood or believed to be deserved	15%
Wanting to protect the perpetrator/wanting to stay in relationship/not wanting to punish perpetrator	14%

Cultural or community concerns	9%
Financial concerns	7%
Housing concerns	4%
Embarrassment	3%

16.3.5 It is well established that all forms of domestic abuse are under reported. Studies have shown that parents are understandably particularly reluctant to disclose or report violence from their child.[18] Whilst it has been established that George contacted the police on two occasions about Nathan's behaviour it is clear that much of Nathan's behaviour was managed or tolerated within the family. The DHR panel cannot now know the reasons for this but it is highly likely that a reluctance to report his own child to the police as a factor in George's decision making. Male victims can experience shame and embarrassment that can prevent disclosure. Additionally when the perpetrator is the person's child there are internal barriers, including fear of criminalising the child, causing conflict within the family unit and a desire to keep family matters private.

16.4 What knowledge did your agency have of Nathan's drug and alcohol issues and any mental health needs and what services did you provide?

16.4.1 Cheshire Constabulary were made aware of Nathan's mental health from an intelligence report forwarded by Merseyside Police on 6 March 2018. It was identified that Nathan had been detained under section 2 Mental Health Act and transferred to the Bowmere Hospital, Countess of Chester Hospital. Additionally, on 11 May 2018, Cheshire Constabulary were involved with Nathan when he was taken to the COCH where he was eventually sectioned under the MHA and left in the care of other agencies.
Historically, it was known by Cheshire Constabulary that Nathan had a drug and alcohol problem however, there is no recorded documentation to evidence that Nathan was signposted to agencies in respect of this.

16.4.2 Within the review period, Nathan first presented to the CoCH with mental health issues on the 11 May 2018. He was seen by the Psychiatric Liaison Team and detained under the MHA and transferred to Bowmere Hospital. He was returned to the CoCH for medical reasons on the same day (accompanied by a Bowmere Hospital staff member). The CoCH medical actions were in relation to Liver disease as a result of alcohol misuse and alcohol withdrawal. Nathan

[18] Condry and Miles 2014

was also seen on more than one occasion by the Hospital Alcohol Liaison Service (HALS) he was offered and had agreed to a referral to Turning Point.

16.4.3 CWP records indicated that practitioners appropriately assessed and responded to Nathan's risk of harm to self and his alcohol use, but there are some identified concerns about whether practitioners considered the impact of Nathan's risk-taking behaviours and harm towards others which have already been explored in paragraphs 16.1 and 16.3.

16.4.4 There is an indication in CWP records that Nathan had a good understanding about the impacts of his alcohol use in relation to his mental health, including increased risk behaviours. Nathan completed an AUDIT on 3 March 2018, which scored 15, suggesting he was at increased risk of hazardous or harmful alcohol use. Following a review of his alcohol use on 11 May 2018, the AUDIT scored 32, suggesting alcohol dependency and harm. This was not discussed with Nathan during his inpatient stay. It is highly unlikely that Nathan answered the AUDIT questions truthfully given that he now acknowledges drinking two bottles of wine and four cans of lager a day. However, AUDIT relies on self-reporting and clinicians would also use other clinical judgments and clinical risk assessments and not solely rely on the Audit tool.

16.4.5 The clinical records indicated there were professional concerns around Nathan's illicit substance use when he presented to AED on 1 March 2018 and 11 May 2018. However, the clinical records suggested that practitioners did not seek to clarify whether Nathan was using illicit substances via urine testing or exploring further with Nathan or members of his family during both inpatient episodes.

16.4.6 CRHT explored Nathan's alcohol use with him during the home visit on 7 March 2018, he informed CRHT that he was planning to access alcohol support when he returned from holiday. The records indicate that risks around alcohol relapse were discussed with Nathan but, he declined to attend a joint appointment with CRHT and community alcohol services.

16.4.7 On 11 May 2018, Nathan was initially seen by HALS in AED, COCH. HALS was informed by Nathan that he is not accessing support from community alcohol services. HALS discussed safe alcohol reduction and advised Nathan to consider a referral to community alcohol services. HALS documented observations around Nathan's behaviour which indicated he may be under the influence of illicit substance, HALS recommended a urine sample should be obtained to screen for illicit substances. There is no evidence that this was

done. HALS reviewed Nathan on 14 May 2018 Nathan gave his consent to be referred to the community alcohol service, Turning Point on 21 May 2018.

16.4.8 Although, there were indicators of risk reported by Nathan to practitioners in relation to illicit substance use, there is no record to suggest that practitioners fully assessed the impact of illicit substance and alcohol use and associated risk factors for Nathan and to others.

16.4.9 There is information to demonstrate the GP was aware of Nathan's drug and alcohol misuse. The GP had tried to support Nathan to engage with services to help manage and reduce his drug and alcohol misuse. The GP Practice received information following hospital admission to confirm Nathan was referred into the Hospital Alcohol services and Mental Health services following admission 11 May 2018.

16.5 **What knowledge or concerns did the victim's family and friends have about the family's victimisation by Nathan and did they know what to do with it?**

16.5.1 Historically, the immediate family were well aware of Nathan's behaviour in respect of them and it is known that all family members knew how to report the poor behaviour to police. This avenue was utilised by Mary in the main and George on two occasions. Peter also instigated a restraining order against Nathan. No ongoing support was offered to Mary after contact with the agencies.

16.5.2 There are no CoCH records pertaining to Nathan "victimising" the family, the scenes and information depicted in the CoCH records are those of a family member who is seriously mentally unwell and a mother trying to support Nathan and ensure health professionals had an accurate reflection of Nathan's situation. At no point do CoCH records evidence that Nathan was naming any specific family member that he needed to target to keep himself safe and there is no thread through the records that could suggest any one family member, or any other specific person was being victimised by Nathan.

16.5.3 The CWP records indicate that there were opportunities for Mary to report any concerns about Nathan's risk behaviour, alcohol use and the impact on family relationships. It is evident that practitioners did discuss his alcohol use and Nathan reportedly acknowledged his alcohol consumption was impacting on his risk of harm to self. Practitioners spoke to Mary on a number of occasions on her own when it would have been possible for her to disclose any issues of

domestic abuse within the family. She was not asked directly about domestic abuse as there were no overt indicators to professionals that domestic abuse was present within the family. Professionals were focussed on the risks that Nathan claimed he faced, for example from people to whom he claimed he owed money and accepted that this was the reason he had been said to be in possession of a knife on 11 May 2018.

16.5.4 There is no information in the GP records that Nathan is known to have victimised his family.

16.6 **What knowledge did your agency have that indicated Nathan might be a perpetrator of domestic abuse and what was the response, including any referrals to a Multi-Agency Risk Assessment Conference [MARAC] or MAPPA?**

16.6.1 Between 2009-2012, NPS managed Nathan via a level 1 MAPPA. During the period under review no other agency had the cause to refer Nathan for a MAPPA or MARAC.

16.6.2 Between 2006 - 2013 incidents of domestic abuse were reported to Cheshire Constabulary. These all concerned Nathan.

1. Mary was pushed to the floor, Nathan was 16 years old.
2. A verbal altercation regarding persons allowed at the address, Nathan was 17 years old.
3. Threats to smash the house up when Nathan was 23 years old.
4. Threats to George and Peter, when Nathan was 23 years old.

16.6.3 Whilst this historic information is included to give appropriate context the incidents were before the review period.

16.6.4 Members of staff at the CoCH did not suspect that Nathan was a perpetrator of Domestic Abuse to any of his family members.

16.6.5 A referral to MARAC was not completed by any professional because there were no concerns around domestic abuse reported by the family or identified by practitioners during the period of the review.

16.6.6 There is no information that the GP Practice had any indications Nathan might be a perpetrator of domestic abuse.

16.6.7 The panel considered whether given Nathan's evidenced behaviour there was

an opportunity to refer him to MAPPA. CWP can refer a case for MAPPA Level 2 or 3 management if it meets the criteria for such. If accepted, Police would then chair the meetings. The criteria taken from the current MAPPA Guidance is;

<u>Category 3 Offenders: Other Dangerous Offenders</u>
This Category contains offenders who do not meet the criteria for either Category 1 or Category 2 but who have committed an offence indicating that he or she is capable of causing serious harm and requires multi-agency management at Level 2 or 3. The offence does not have to be one specified in Sch.15 of the CJA 2003 and may have been committed abroad.
To register a Category 3 offender, the Responsible Authority must establish that:
1) the person has either:
- *a conviction for any offence (current or historic, within the UK or abroad); or*
- *received a formal caution (adult or young person) or reprimand/warning (young person) for any offence; or*
- *been found not guilty of any offence by reason of insanity; or*
- *been found to be under a disability (unfit to stand trial) and to have done any act charged against him or her;*

and
2) the offence for which they received the disposal in paragraph 6.11(a) above indicates that the person may be capable of causing serious harm to the public.

16.6.8 Nathan met the criteria for MAPPA referral based on his previous offending. Notwithstanding this, in order to be referred under Category 3, he would then have to meet the following criteria also drawn from the MAPPA guidance:

16.6.9 *Offenders should not be registered as Category 3 unless a multi-agency approach at Level 2 or 3 is necessary to manage the risks they present. The current risks do not always have to relate directly to the offence in paragraph 6.11(a) above.*
In some cases, the offence in paragraph 6.11(a) above will be of a clearly sexual or violent nature, although it need not be listed in Sch. 15 of the CJA 2003. However, in most cases, it will be appropriate to examine the circumstances surrounding the offence in order to establish whether the offender may cause serious harm. Offenders demonstrating a pattern of offending behaviour indicating serious harm (e.g. domestic abuse or gang

related violence) or an escalation in risk of serious harm (e.g. deterioration in mental health or escalation in alcohol misuse) that was not reflected in the charge on which the offender was actually convicted should be considered for category 3 management.

16.6.10 A MAPPA referral is usually made where there are barriers to risk management and additional partners need to be brought in to assess and manage those risks. To be accepted for MAPPA management it would need to be clear what value would be added by the process in terms of improving multi-agency risk management or compelling partners to work together more effectively.

16.6.11 The panel heard that even if a referral had been made it would have been unlikely to have been accepted for MAPPA management for the following reason.

- The only current indication of risk to family held at the time, was the information the Police and CWP held about Nathan potentially having been in possession of a knife and causing his father to be concerned for his own safety. A knife was not found in Nathan's possession and police acted to ensure Nathan got the medical help he needed.

16.7 **How did your agency take account of any racial, cultural, linguistic, faith or other diversity issues, when completing assessments and providing services to the subjects of the review?**

16.7.1 All subjects of the review are white British. They were living in an area which is predominantly of the same culture. There is no evidence arising from the review of any negative or positive bias on the delivery of services to the subjects of the review. See paragraph 11.

16.8 **Did your agency follow its domestic abuse policy and procedures, and the multi-agency ones**?

16.8.1 There were no perceived domestic abuse incidents reported to Cheshire Constabulary in the time frame under review.

16.8.2 There is no indication in the clinical records to suggest that practitioners believed that Mary or George were at risk of domestic abuse from Nathan. The CARSO documentation and risk management plan for Nathan indicates that the carer views of risk were not fully captured. The following questions should have been considered and were not.

- Do carers think there is a problem?

- What is their report of past harm to others including violence? Who to, in what way, how severe was it?
- What has helped in the past?
- Is the situation deteriorating?

16.8.3 Therefore, the CARSO did not adhere to CWP Clinical Risk Assessment Policy. This was a missed opportunity to understand family dynamics.

16.9 Did professionals recognise that the conflict in the family amounted to domestic abuse?

16.9.1 Prior to 2013 the Association of Chief Police Officers (ACPO) definition for domestic abuse adopted by Cheshire Constabulary was

'any incident of threatening behaviour, violence or abuse between adults, aged 18 and over, who are or have been intimate partners or family members, regardless of gender and sexuality.' (Family members are defined as mother, father, son, daughter, brother, sister and grandparents, whether directly related, in-laws or step-family. Intimate partners include current and previous.)

16.9.2 Therefore, the historic incidents that were reported for example an assault by Nathan on his mother were not recorded as domestic abuse because Nathan was at that time under 18 years of age.

16.9.3 From 2013, the ACPO definition changed to.

"*Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass, but is not limited to, the following types of abuse: Psychological, physical, sexual, financial and emotional."*

16.9.4 When George called the police on 11 May 2018 because he was concerned for his own safety, the incident clearly fitted the 2013 definition of Domestic Abuse. The incident was treated by the police as a person suffering from a mental health episode. The officers ensured that Nathan was taken to hospital where he received appropriate treatment. However, the incident should have been recognised as fitting the description of Domestic Abuse as well as a mental health issue and a VPA and DASH risk assessment should have been completed. The panel thought that had someone else, for example, a girlfriend contacted the Police in the same circumstances then it would have been more

likely that Domestic Abuse was recognised.

16.9.5 The CWP clinical records indicate that practitioners did not observe or identify any conflict in the family to suggest there were domestic abuse concerns but, it should be highlighted that practitioners did not seek to obtain George's or any other family members views to gain more understanding of Nathan's risk behaviour and the impact on family relationships.

16.9.6 The CoCH records do not evidence that Nathan was making any specific threats to family members. This case was not seen as a case of Domestic Abuse.

16.9.7 There is no evidence in the GP information reviewed that professionals were aware of any conflict in the family that amounted to domestic abuse.

16.10 **Were there issues in relation to capacity or resources in your agency that impacted on its ability to provide services to the subjects of the review, or on your agency's ability to work effectively with other agencies?**

16.10.1 There were no reported issues in relation to capacity or resourcing by the contributing agencies.

16.11 **What learning has emerged for your agency?**

16.11.1 CWP Practitioners were aware of Nathan's history of harm to others when intoxicated. Mary was spoken to however, there is no record to indicate if this was explored further with George or other family to establish how this was impacting on his relationship with Nathan. In cases where it has been assessed that there is a risk history to the family, attempts should be made by practitioners to discuss this with all family members who are the focus of that risk to ensure that their individual views and concerns are captured and can contribute to the risk assessment and management plan.

16.11.2 Nathan had described some risk behaviour which could be attributed to his illicit substance and alcohol use. The misuse of alcohol was evidenced by his medical conditions however, there is no evidence that he was tested for illicit drugs or that information was sought from other family members to support this.

16.11.3 The clinical records indicate that Nathan's risk behaviours were attributed to his alcohol use with him denying any substance use. However, this was at odds with Nathan saying that he owed ten thousand pounds to drug dealers. This

needed further exploration by CWP practitioners.

16.12 **Are there any examples of outstanding or innovative practice arising from this case?**

16.12.1 The panel did not identify any examples of outstanding or innovative practice.

16.13 **Does the learning in this review appear in other Domestic Homicide Reviews commissioned by Cheshire West and Chester Community Safety Partnership?**

16.13.1 Cheshire West and Chester Community Safety Partnership has been responsible for two previous DHRs. The learning and recommendations from those reviews have been reviewed and do not appear in this case.

16.4 **To answer questions which George's family may ask.**

Mary asked that three questions be answered by the review. They were;

Q1. When someone visits A&E saying they are hearing voices, wants to kill himself etcetera, why was Nathan allowed to walk away?

Nathan had recently been detained in hospital for assessment under the Mental Health Act on two occasions. On both times his symptoms were assessed as being due to alcohol consumption and not mental ill health. He had continued drinking since his last admission to hospital and CWP practitioners discussed options with Nathan to enable him to address his alcohol use. He gave consent to a referral to community alcohol services (Turning Point). Clinical risk information suggests that Nathan risk behaviours were attributed to his alcohol use with him denying any recent illicit substance use. Nathan was not assessed as needing detention under the Mental Health Act on this occasion and therefore there was no legal power to detain him or prevent him from leaving the hospital.

Q2. There is concern regarding the time lag between being seen in A&E and next contact with adult mental health services (2 days). They then arranged a visit saying would be between 10-12pm on the Monday called to say running late and it would be 2pm and then didn't turn up until 5pm. Nathan did not let them in. If they had called his Mother to say when they were coming she would have arranged to have been there and ensure

Nathan was seen.

Nathan would have been allocated to a pre-arranged time slot for a home visit. However, there are occasions where CRHT visits may be delayed, particularly in those situations which may require the practitioners to take immediate action and therefore, may impact on those individuals who are due to be visited at home. On 1 June 2018 at 15.30 hrs, CRHT practitioners did attend Nathan's home address and a card was posted through his letterbox requesting Nathan to contact CRHT. CRHT make a telephone call to Nathan to arrange a home visit on 2 June 2018, Nathan requested that he did not have any visits until 4 June 2018 as he had plans for the weekend. He agreed to contact CRHT via telephone if required. There was no further contact despite attempts at home visits to Nathan's home address and telephone on 4 June 2018, 6 June 2018 and 8 June 2018. There were failed contacts from both CRHT and EIT practitioners to contact Nathan's Mother via home address and telephone on 4 June 2018, 8 June 2018 and 12 June 2018. On one occasion a practitioner did speak to George and asked that Nathan contact CRHT.

Q3. *Nathan was seen in A&E and it was agreed to admit Nathan to Bowmere. However, it took from 2pm until 7pm for Nathan to be transferred to Bowmere Hospital.*

A bed on Beech ward was sourced and booked following Nathan's mental health assessment on 11 May 2018 at 5.30pm. The bed on Beech ward Bowmere Hospital did not become available until 7.30 pm when Nathan was admitted. In the experience of the chair and author of the review this appears to have been an efficient and prompt admission.

17 CONCLUSIONS

17.1 Nathan had a long history of poor behaviour both towards his family and others. It seems that he had drunk excessive amounts of alcohol every day for many years.

17.2 On some occasions his family sought help and reported his actions to the police, for example a restraining order was in place for a period preventing contact with his brother. There were many other minor incidents which were managed within the family.

17.3 Despite the issues that Nathan caused, his parents continued to support him. Nathan's mother was very supportive, arranging for somewhere for him to live

and often paying the rent when he had spent his own money on alcohol. Despite the times that they were estranged the family kept in touch and came back together. In the period before George's murder Nathan was spending at least a few days every week at his parent's home. There is no evidence that George's family were signposted to charities that help families who have relatives who abuse alcohol or drugs.

17.4 When the Police attended at George's home address on 11 May, he had stated that he felt concerned for his own safety due to Nathan's behaviour. This incident clearly fitted Cheshire Constabulary's definition of Domestic Abuse. As such a VPA and DASH risk assessment should have been completed by the attending officers. Had an assessment been conducted which considered all of the historical information available this may have resulted in the family being offered support.

17.5 During the period under review Nathan was sectioned under Section 3 of the Mental Health Act in March 2018 and May 2018 and detained in Bowmere Hospital. On both occasions he told staff that he was being pursued by drug dealers for a debt and that they had damaged his parents' house. He also referred to his father and grandfather attempting to take their own lives. These have now been shown to be fictitious. Nathan's mother was aware of what was actually happening and if she had been consulted then this may have better informed the professionals risk assessments.

17.6 On being discharged from the hospital there was a plan to involve Nathan with services that could assist his alcohol misuse and mental health issues. This was similarly the case when he left the CoCH AED in May 2018. Nathan had a long history of not engaging with services and a partnership approach with his family, in particular his mother may have better facilitated engagement with services.

17.7 On the last occasion that Nathan attended hospital on 31 May 2018 he became agitated and left the hospital. Staff assessed that his issues were being caused by alcohol and not mental health issues. Nathan's family believe that he should not have been allowed to walk out of hospital unchallenged. Whilst that view is understandable, medical professionals had no grounds on which to detain him under the Mental Health Act.

17.8 Many attempts were made by mental health practitioners to contact Nathan and provide support following his discharges from hospital. Most were unsuccessful. The panel concluded that given the level of effort evidenced that

it is highly likely that Nathan deliberately avoided contact. This may have been because he chose not to address his alcohol misuse and professionals would have brought him back to this.

17.9 Two weeks after his last contact with medical professionals Nathan suddenly and without warning attacked George with a knife and killed him. Nathan himself cannot explain his actions and there were no warning signs apparent to his family in the hours leading up to the attack.

18 LEARNING

18.1 Narrative

18.1.1 Police officers did not recognise that when George reported being concerned for his own safety due to Nathan concealing a knife that this amounted to domestic abuse.

Learning

18.1.2 There is a continuing need for training and education for professionals in domestic abuse which recognises that parents can be victims.

18.2 Narrative

18.2.1 Health professionals accepted what Nathan said about drugs debts, his father and grandfathers alleged attempts to take their own lives and his use of alcohol and drugs without seeking to check any of the information given to them by a patient having a psychotic episode.

Learning

18.2.2 Professionals should seek to triangulate information which may help them to inform a more holistic assessment of a patient which is inclusive of information available from family and partner agencies. This may also contribute to a more holistic risk assessment.

18.3 Narrative

18.3.1 George and Mary were not made aware of help that was potentially available to them, for example charities that offer support to the families of those who misuse alcohol.

Learning

18.3.2 The families of people who misuse drugs and alcohol are often prepared to support them but may not how best to do so.

19 DHR PANEL RECOMMENDATIONS

19.1 Cheshire West and Chester CSP should seek assurance from its partners that learning from this review has been disseminated and that domestic abuse training recognises that parents can be victims. The Home Office information on Adult to Parent Violence should be referenced.

19.2 Cheshire West and Chester CSP should seek assurance from its partners that Professionals seek to triangulate information which may help them to inform a more holistic assessment of a patient/client which is inclusive of information available from family and partner agencies.

19.3 Cheshire West and Cheshire CSP should seek assurances from its partners that where appropriate and possible agencies signpost relatives of those who misuse drugs and or alcohol to appropriate support, for example Alanon.

SINGLE AGENCY RECOMMENDATIONS

19.4 Update Countess of Chester Hospital Domestic Abuse Policy to reflect learning form this case.

19.5 Anonymised case study learning from this case for in-house SG and DA training. (COCH)

19.6 Ensure call out information (VPA) is sought and available to NPS officers when preparing reports for Domestic Abuse offences.

19.7 When risk history around harm to others has been identified, practitioners should consider those individual views and concerns of any family members or significant others when formulating any risk assessment and management plan. (CWP)

19.8 When attempting to work closely with service user families, cares or significant others, their contact details need to be easily accessible on CWP electronic records systems. (CWP)

19.9 When engagement is difficult and there are failed contacts, then consideration should be given to a more active engagement including face to face with families or carers, especially when there is a risk of harm to self or others. (CWP)

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APPENDIX
Cheshire West and Chester Community Safety Partnership (CSP)

No	Recommendation	Scope ie Local/national	Action to take	Lead Agency	Key Milestones Achieved in enacting Recommendation	Target Date	Date of Completion & Outcome
1	The Domestic Abuse Partnership to reassure the CSP that learning from this review has been disseminated and that domestic abuse training recognises that parents can be victims. The Home Office information on Adult to Parent Violence should be referenced.	Local	Domestic Abuse Partnership to confirm that training recognises parents can be victims and the Home Office information is reference.	CSP Domestic Abuse Lead	Once published this review will be disseminated to the Domestic Abuse Partnership and the Local Safeguarding Adults Board The Local Safeguarding Adults Board will ensure that any learning points are incorporated into its safeguarding and training All Domestic Violence and Abuse training will be reflective of learning points from this review	January 2021 Dec 2020 Jan 2021	
2	Statutory partners to assure the CSP that	Local	Statutory partners to provide reassurance to	CSP	The CSP will formally request in its next meeting that this	Dec 2020	

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Cheshire West and Chester Community Safety Partnership (CSP)

No	Recommendation	Scope ie Local/national	Action to take	Lead Agency	Key Milestones Achieved in enacting Recommendation	Target Date	Date of Completion & Outcome
	Professionals seek to triangulate information which may help them to inform a more holistic assessment of a patient/client which is inclusive of information available from family and partner agencies.		the CSP		approach is embedded in practice		
3	Statutory partners to reassure the CSP that where appropriate and possible agencies should signpost relatives of those who misuse drugs and or alcohol to appropriate support, for example Alanon.	Local	Statutory partners to provide reassurance to the CSP	CSP	The CSP will formally request in its next meeting that this approach is embedded in practice The CSP will write to the current substance misuse provider and encourage them to consider how they engage with relatives of service users	Dec 2020 Dec 2020	

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					The CSP Chair will alert the Substance misuse partnership of this recommendation	Dec 2020	
4	Update Countess of Chester Hospital (COCH)Domestic Abuse Policy to reflect learning from this case	Local	Update Policy	CSP Health Lead COCH Head of Safeguarding & Complex Care	COCH Policy update commenced in January 2019, this is the first step in an aim to further improve Domestic Abuse response in the Accident and Emergency Department	Dec 2020	
5	Anonymised case study for learning from this case for in-house Safeguarding and Domestic Abuse training.	Local	Write case study and include in training	CSP Health Lead	To be incorporated within think family training as part of a full review of all training. To be incorporated into COCH Safeguarding Children and Domestic Abuse training To be shared via the	March 2021	Training Review will be completed by March 2021

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					COCH Chief Executive weekly information update		
6	Ensure call out information (VPA) is sought and available to National Probation Service officers when preparing reports for Domestic Abuse offences	Local (Cheshire wide)	Cheshire Police and National Probation Service to work together to ensure the provision of call out information (VPA) to inform Court reports	CSP Police Lead & CSP Probation Lead	Niche access for one admin staff within Cheshire National Probation Service for the 24hr information Information Sharing Agreement in place. Police and Probation to consider Niche access in the Courts to ensure we have the information for DV Court reports.	March 2021	March 2020
7	When risk history around harm to others has been identified, practitioners should consider those individual views and concerns of any family members or	Local	Training regarding risk assessment and management to be reviewed to ensure the learning is	CSP Health Lead	Learning of the case to be shared with practitioners and teams. Training review completed. Future audit to be planned to review	April 2020	A Shared Learning Bulletin has been disseminated to all Cheshire Wirral Partnership

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Cheshire West and Chester Community Safety Partnership (CSP)

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	significant others when formulating any risk assessment and management plan.		embedded into practice.		effectiveness of training.		(CWP) practitioners via email communication and governance processes. Bulletin circulated on **23/10/2019** Reflective review meetings were held with staff teams directly involved in the clinical care of this service user on **05/12/2019** **4/11/2019** Meeting held with service leads and safeguarding practitioner to review the single

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							agency action plan a series of dip sample audits to ensure that data relating to next of kin significant others were being recorded in clinical records. Weekly record audits are undertaken, and these details are now included. **This is a weekly task undertaken by clinical leads.** Progress of DHR action plans are discussed at the Trust Wide

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							Safeguarding Committee, this is ongoing until completion and sign off. The action plan will be presented at the quality safeguarding and learning forum for specialist mental health on **02/11/2020** CWP is planning to review its domestic abuse policy. First meeting date to agreed CWP mandatory safeguarding Family (levels 2

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							and 3) have been revised to incorporate Interfamilial Domestic Violence Coercion and Control. Training programme has been delivered since **October 2019.** 94% of staff have undertaken level 2 training and 75% have undertaken level three. Risk indicators concerning mental health, substance misuse and

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							domestic violence have been enhanced within the training package and have been added to the CWP Safeguarding Screening Tool which went live **09/03/2019.** The safeguarding adults team have a plan to audit the use of the screening tool in **December 2020**
8	When attempting to work closely with service user families, cares or significant others, their	Local	Managers to inform staff of the importance of including	CSP Health Lead	Next of Kin / significant others information to form part of core information of patient	May 2020	CWP Safeguarding Screening Tool has been revised

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	contact details need to be easily accessible on CWP electronic records systems		significant others details within the patient record and to complete a dip sample audit to determine improved practice.		records. Learning of the case to be shared with practitioners and teams. Completion of audit, analysis of findings.		to incorporate Next of kin /nearest relative/ significant others. **March 2020** A Shared Learning Bulletin was disseminated to all CWP practitioners via email communication systems **October 2019** The learning outcomes have been shared with CWP Locality/care group safeguarding

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							meetings and safeguarding practice link meetings. **Completed** A weekly 'dip' sample of service user records are audited by CWP Clinical Leads to ensure next of kin /nearest relative/ significant other's details are accurately recorded. Working practice intelligence is collected from: DATIX incident reporting

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							CWP Safeguarding Children/Adult enquiries Safeguarding supervision with CWP practitioners. **This is an ongoing weekly dip sample.**
9	When engagement is difficult and there are failed contacts, then consideration should be given to a more active engagement including face to face with families or carers, especially when there is a risk of harm to self or others	Local	To review the non- engagement processes for the service to ensure that a proactive approach to include significant others is taken.	CSP Health Lead	Learning of the case will be shared with the triangle of care lead for CWP to inform implementation of such. Future audit to be planned to review the effectiveness of changes in practice.	July 2020	Case file audits have been completed by CWP Safeguarding Adults Team. **January 2010.** A further audit will be factored

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							into CWP Safeguarding Adults audit plan to establish if the learning has enhanced knowledge and understanding of: Interfamilial Domestic Violence and abuse Coercion and Control, Association and risk indicators of mental health, substance Misuse and domestic

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							violence and abuse **March 2021**

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