Milton Keynes Community Safety Partnership

DHR Overview Report

Domestic Homicide Review of the death of Anthony (a pseudonym) in June 2015

Professor Louise Westmarland
(Independent Chair)

Final Version

ADDENDUM

The MK Together Partnership accepts that this review, which pre-dates the Partnership, has taken too long to complete. We have made changes to our governance and quality assurance processes to prevent this from happening again. We accept that language used in this report is no longer relevant to or appropriate for families and agencies, including terminology such as Toxic Trio and descriptions of sexuality, however, is reflective of the time in which it was written. We can assure Milton Keynes residents and the family of the victim that learning has been taken from this review and work continues within the partnership to prevent all forms of domestic abuse."

We would like to offer our condolences to the family of the victim and hope that the publication of this review can bring some closure and comfort."

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1. INTRODUCTION

This Domestic Homicide Review is being conducted in order to consider the circumstances around the death of a young man we are calling 'Anthony' in order to preserve his anonymity. The sad and early loss of a vibrant and much-loved son, brother, uncle and nephew, in circumstances which are still not exactly clear, is kept in mind throughout the following report.

The key purpose for undertaking DHRs is to enable lessons to be learned from homicides where a person is killed as a result of domestic violence and abuse. In order for these lessons to be learned as widely and thoroughly as possible, professionals need to be able to understand fully what happened in each homicide, and most importantly, what needs to change in order to reduce the risk of such tragedies happening in the future.

This report of a domestic homicide review has examined any agency responses and support given to Anthony (a pseudonym), a resident of Milton Keynes, prior to the point of his death in June 2015. It has also considered the role and background of the perpetrator, Terry (also a pseudonym), his background and issues leading up to the homicide.

At the time of the fatal incident the victim, Anthony, was aged 31. The perpetrator, Terry, was aged 25; both men of White British ethnicity.

In addition to agency involvement the review has examined past events 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 has sought to identify appropriate solutions to make the future safer.

The circumstances leading to a review being undertaken in this case were that the victim and perpetrator were involved in an intimate, although casual, personal relationship.

In addition to considering agencies' contact/involvement with the victim, Anthony, this Review has also sought background details from his family and friends. Terry's contacts with agencies and his family background and past relationships are also explored. The main period these details cover, as indicated in the Terms of Reference (ToR) is from July 2013 to June 2015. This period covers two years prior to the victim's death. This was decided to be appropriate as the relationship between the victim and perpetrator had only been for a period of weeks before the fatal incident.

TIMESCALES

This review began on 9 December 2016 and was concluded on 8 August 2019. Home Office Guidance states, domestic homicide reviews (DHRs), including the overview report, should be completed, where possible, within six months of the commencement of the review.

There was quite a long period at the beginning of the process whilst a suitable DHR Chair was being sought. There also seems to have been some debate about whether this was a) a homicide and b) a domestic homicide following notification of the process commencing.

This appears to have delayed the commencement of the appointment of the Chair due to these uncertainties.

A number of issues delayed the completion of this DHR, and although there were meetings between the Chair and CSP members of staff, the final Panel meeting did not take place until July 2019 for a number of reasons. These included; a shortage of dedicated support staff capability at the Milton Keynes Council partly due to austerity measures; there was also a period of maternity leave by a key member of staff and austerity measures did not allow sufficient cover for her post; this led to a lack of time and ability to convene a suitable panel partly due to the requirement to have a member of the LGBT community present. This last reason proved extremely difficult to resolve as the LGBT organisation that Council usually approaches was also going through a period of change of governance.

Ongoing was a long period (12 months in total) of negotiation with the prison Offender Manager where the perpetrator was held. This involved monthly, and in some cases weekly emails to the officer concerned by the Chair. At one point, about 6 months into the conversation, the officer explained that she felt that as the perpetrator was making such good progress she did not want to ask him to take part. Following this, contact with the prison Governor expediated matters, but arrangements still took some time. Once permission was eventually obtained, a further protracted period of negotiation about the timing, format of the meeting and the sort of questions that might be posed took place with the perpetrator via his mother. The Chair felt that once this process of trying to obtain access to the perpetrator had begun it would have been disappointing not to proceed.

Delays also occurred due to the inability of the victim's GP practice to supply the DHR Chair with the required details. Eventually, the Chair had to visit the practice herself in person to obtain their co-operation. The GP practice did not seem aware of the DHR process and had been ignoring all communications. On the day she visited they claimed there was 'no-one in charge' of the practice and were unwilling to deal with the DHR Chair which led to further delays whilst information was sought via Council officers. There was also a problem with obtaining information from Northamptonshire agencies, such as details of police related incidents as their support system providing details to DHRs is now centralised in Birmingham. Getting through to the relevant person was time consuming.

Some of these problems were also related to austerity and a lack of DHR dedicated support staff at Milton Keynes Council. One of the time problems was that Council staff did not have the capacity to follow up on certain issues – such as the victim's medical records for example, or to explore other local LGBT possibilities. Some panel members were also under extreme pressure due to a lack of support and were therefore unable to meet at regular intervals. This led to protracted periods of inactivity where the Chair was waiting to have meetings confirmed, and for information with which to furnish the panel for the meeting.

CONFIDENTIALITY

The findings of Domestic Homicide Reviews are confidential. Information is available only to participating officers/professionals and their line managers and the family of the victim. Names of all participants have been changed and some personal details omitted. The Chair

suggested a pseudonym for the victim, 'Anthony' and for the perpetrator 'Terry' and gave other participants pseudonyms. She discussed this originally with family members who were unwilling to suggest names as they wished to keep their loved one's real name in the report. Home Office guidance does not recommend this practice, and the Chair is still negotiating this with the family who have not yet been allowed to see a draft of this report. It is hoped that once they see the final version they will agree to the name change.

2. TERMS OF REFERENCE

Purpose:

The purpose of a Domestic Homicide Review is to:

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

DHRs are not inquiries into how the victim died or into who is culpable; that is a matter for coroners and criminal courts, respectively, to determine as appropriate.

The DHR Independent Chair ensured the review was conducted according to best practice, with effective analysis and conclusions of the information related to the case.

Overview and Accountability:

The Home Office was informed of the decision to undertake a Domestic Homicide Review in **June 2015**. The Statutory Guidance advises where practically possible the DHR should be completed within six months of the decision made to proceed with the review.

This Domestic Homicide Review was conducted within the spirit of the Equalities Act 2010, to an ethos of fairness, equality, openness, and transparency, and carried out in a thorough, accurate and meticulous manner.

Scope of the Domestic Homicide Review:

This Domestic Homicide Review (DHR) has considered an overview of each agency's involvement in detail between the beginning of **July 2013 and the end of June 2015 for Anthony and Terry.**

This is a period of approximately two years leading up to the death of Anthony in June 2015.

Further, this DHR has considered any other information of relevance from before 1 July 2013. Although the definition of 'relevance' was at the discretion of the individual IMR

writer's professional judgement and his or her organisation's chief executive, this includes (for both Anthony and Terry):

i) Any incidents or disclosures involving violence and abuse
ii) References to the misuse of alcohol and drugs
iii) Any health-related issues
iv) The engagement and offering of services and support.

This has included relevant details of:

- Whether there was any previous known history of abusive behaviour between either individual, or with any other previous partners.
- Whether family, friends or colleagues wanted to participate in the review and whether they were aware of any abusive behaviour to the deceased, prior to the death.
- Whether, in relation to the family members, any barriers were experienced in reporting domestic abuse.
- Whether there was any contact with agencies in relation to substance misuse, the outcomes of any contact, and to what extent substance abuse was related to abusive or violent behaviour between the victim and perpetrator.
- Whether improvement in any of the following might have led to a different outcome:

    a) Communication and information sharing between services including in relation to the safeguarding of children and adults

    b) Communication within services

    c) Communication to the general public and non-specialist services about available specialist services such as those aimed at supporting victims of domestic abuse.

- Whether the work undertaken by agencies in this case was consistent with:

    a) Organisational and professional standards
    b) Organisations' domestic abuse and safeguarding policies, procedures and protocols

- The response of the relevant agencies to any referrals relating to or concerning domestic abuse or other significant harm from 1st July 2013 and any relevant earlier records. It has sought to understand what decisions were taken and what actions were carried out, or not, and establish the reasons for these. In particular, the following areas were explored:

    a) Identification of the key opportunities for assessment, decision making and effective intervention in this case from the point of any first contact onwards with the deceased.

b) Whether any actions taken were in accordance with assessments and decisions made and whether those interventions were timely and effective.
c) Whether appropriate services were offered/provided and/or relevant enquiries made in the light of any assessments made.
d) The quality of any risk assessments undertaken and if relevant, whether appropriate information-sharing and handover occurred.

- Whether thresholds for intervention were appropriately assessed and applied correctly, in this case.
- Whether any identified issues were escalated to senior management or other organisations and professionals, and if appropriate, carried out in a timely manner.
- Whether the impact of any organisational change over the period covered by the review had been communicated well enough between partnership agencies and whether that impacted in any way on agencies' ability to respond effectively.
- Whether any training or awareness raising requirements can be identified to ensure a greater knowledge and understanding of domestic abuse and safeguarding processes and/or services in the future.
- The review has considered any relevant protected characteristics as outlined by the Equalities Act 2010.
- The review has considered any other information found to be relevant.

3. METHODOLOGY

3.1 Following the report by Thames Valley Police of Anthony's death, the decision to undertake a DHR was made by Milton Keynes Community Safety Partnership, *SaferMK*. This involved Mr Colin Wilderspin, then Head of Community Safety, with the decision made by the Chair of the CSP. This decision was made because the victim and perpetrator were involved in a short-term intimate partner relationship.

The Community Safety Partnership then began the process of commissioning an independent reviewer to Chair the DHR Panel meetings and produce the Overview Report and Executive Summary.

Initial requests to preserve records were made on behalf of *SaferMK* to statutory agencies in accordance with Home Office guidance.

The Panel received a report by the relevant Thames Valley Police Senior Investigating Officer (SIO) in person and considered whether any further panel members should be co-opted.

The documents considered were as follows:

3.1 AGENCY RESPONSES

Milton Keynes Community Safety Partnership - *Safer MK* - received IMRs from:

Thames Valley Police

Northamptonshire Police

Anthony's GP Practice

Terry's GP practice (following intervention from the DHR Chair)

Milton Keynes Community Safety Partnership (CSP) received responses indicating that neither the victim nor perpetrator were known to their agency from:

Northamptonshire Safeguarding Adults Board

CNWL Divisional Safeguarding Adults lead for Milton Keynes

Children's Social Care Milton Keynes Council (NB: as no children were involved in this case, this agency contributed no further part in this Review).

MK-Act

3.2 INVOLVEMENT OF FAMILY, FRIENDS, WORK COLLEAGUES, NEIGHBOURS AND WIDER COMMUNITY

3.3 **The victim's family**

Anthony's family were contacted by letter, phone and in person by the DHR Chair and provided with the relevant Home Office DHR leaflet. The family has not had the help of a specialist and expert advocate but were provided with leaflets for relevant organisations such as Advocacy After Fatal Domestic Abuse (AAFDA) and how to contact them.

The terms of reference were shared with the family to assist with the scope of the review and the family met the review panel and have been updated since April 2017 when contact was first made.

The family attended the second meeting of the DHR Panel on 15 January 2018

The chair conducted a number of personal interviews that including Anthony's mother, older sister, and other close members of the family including an aunt and uncle and other sisters.

They have reviewed the draft report in private with plenty of time to do so and have had the opportunity to comment and make amendments if required.

Personal Interviews:

The chair conducted a number of personal interviews.

- Colin (Anthony's self-identifying best friend and former landlord)
- Terry, the perpetrator
- Naomi, The perpetrator's mother
- The perpetrator's prison Offender Managers (2)

Over a 12-month period the prison authorities were contacted by email and phone. At first the perpetrator's Offender Manager said that she thought it would not be a good idea to meet with Terry as he was 'making good progress'. Subsequently, following a number of emails explaining the DHR process, it was agreed that if Terry agreed, then the interview could take place.

Following this, the perpetrator's mother, Naomi, was contacted and asked if she could help with the process. After several phone calls and emails, it was agreed that Terry would be interviewed if she could be present.

At the interview with Terry, in prison, his mother was present throughout, as agreed. In addition, the two Offender Managers, insisted they would remain in the room and take part in the discussion.

All those contributing were able to do so using the medium they preferred and it was made clear that they were not under duress to take part.

3.4 CONTRIBUTORS TO THE REVIEW

IMRs were received from:

Thames Valley Police

Northamptonshire Police

Anthony's GP Practice

Terry's GP practice

All authors were confirmed to be independent in that they had no involvement with the victim, perpetrator or their families or friends prior to their authorship of their IMR report.

Interviews conducted with:

Anthony's family, including his mother, sister and wider family

Anthony's best friend

Terry (the perpetrator)

Terry's mother (in person with Terry and numerous phone calls and emails)

Two of Terry's Offender Managers

Oral Report

Thames Valley Police Senior Investigating Officer Detective Sergeant Steven Ring

3.5 THE REVIEW PANEL MEMBERS

- Louise Westmarland, Independent DHR Chair
- Jo Astor, Network Rail representing Q Alliance
- Sue Burke – CEO, MKAct*
- Jane Harrison, Head of Communities, Milton Keynes Council
- Jo Hooper, Head of Safeguarding, Children & Families, Milton Keynes Council
- Nicole Murphy, Detective Chief Inspector, Milton Keynes LPA, Thames Valley Police
- Eleanor Nickless, Head of Homelessness Prevention & Housing Access, Milton Keynes Council
- Helen Pritchard, Chair, Q Alliance
- David Pennington, Safeguarding Adults; Mental Health & Learning Disability Lead, MKCCG
- Steven Ring – Detective Sergeant, Major Crime Unit, Thames Valley Police
- Michelle Smith, Head of Service, Adult Social Care, Milton Keynes Council
- Lorraine Williamson, Crisis Intervention Service Team Manager, MKAct*
- Colin Wilderspin – Community Safety Lead, Milton Keynes Council (to February 2018)
- Mark Wolski – Community Cohesion Manager, Community Safety, Milton Keynes Council
- Lisa Lovell, Community Safety Officer, Milton Keynes Council
- Sophie Ward/Jordan – Public Health Project Support Officer, Milton Keynes Council

* MK-Act is a local voluntary agency supporting victims of Domestic Abuse

3.5.1 The Panel met on the following dates:

14 December 2016

15 January 2018, 4 - 6 pm (with family members from 6pm)

15 March 2018

11 July 2019

Independence of IMR writers was confirmed by all Panel members on behalf of their organisations at the meeting on 15 January 2018.

3.6 AUTHOR OF THE OVERVIEW REPORT

The Community Safety Partnership commissioned and independent Panel Chair and author of the overview report - Louise Westmarland, who is Professor of Criminology at the Open University where she has been employed for the past 16 years. Professor Westmarland conducted this Review as a private consultant. She has undertaken the Home Office approved and accredited training programmes, most recently in 2017 and has chaired four DHRs previously. Professor Westmarland is independent of Milton Keynes Community Safety Partnership and has never worked for any agency in the area. Her PhD, conferred in

1998, has been followed by a career involving over 50 research projects, papers, articles and books, including works on domestic violence, policing, crime and homicide.

3.7 PARALLEL REVIEWS

No parallel reviews were conducted during the period of the DHR. The local Coroner's office has confirmed that an Inquest was not held as the full facts of the case were examined in full during the criminal trial.

3.8 EQUALITY AND DIVERSITY

The panel has been mindful of the need to consider and reflect upon the impact, or not, of the cultural background of Anthony and Terry's sexual orientation and if this played any part in how services responded to their needs.

In this case, the Panel has given special consideration to the issue of sexual orientation as the victim was a gay man. The Panel appointed a member who is a specialist in the field, who works as a volunteer for a local support organisation for the LGBT community. The Panel has considered whether there were any barriers to accessing services due to the victim and perpetrator's sexual orientation as gay men. The way the Milton Keynes CSP engages with LGBT communities has been highlighted as a problem throughout the process of this DHR. This is examined in more detail in the Analysis section later in this Report.

3.9 DISSEMINATION

Anthony's family
CEOs of all agencies supplying IMRs
Milton Keynes CSP
The Home Office
Head of Safeguarding Adults; Mental Health and Learning Disability Lead, MKCCG
Head of Communities, Milton Keynes Council
Chair, Q Alliance
Head of Safeguarding, Children & Families, Milton Keynes Council
Head of Service, Adult Social Care, Milton Keynes Council
Head of Homelessness Prevention & Housing Access, Milton Keynes Council
Detective Chief Inspector, Milton Keynes LPA, Thames Valley Police
Detective Sergeant, Major Crime Unit, Thames Valley Police
CEO, MK-Act

4. BACKGROUND INFORMATION (THE FACTS)

4.1 At the time of the fatal incident the victim, Anthony (a pseudonym), was aged 31 and the perpetrator, Terry (a pseudonym) was aged 25; both men of White British ethnicity.

Anthony was the co-owner of a hairdressing salon in a local shopping parade. In terms of his sexuality, Anthony had come out as gay to his family aged 16. One of the police witnesses said Anthony had met Terry around December 2014 via a dating site, but his family and friends pointed out that they thought that it was only in the past 3-4 weeks of his life that the relationship had become sexual.

Thames Valley Police have recorded that the victim, Anthony, was living as a lodger in a friend's apartment. His death occurred in one of the bedrooms of the apartment. Police were called to the property near to midnight one evening in early June 2015 due to being alerted to a fire in progress.

When police and the fire service arrived and forced entry to the flat, Anthony's body was found and the Ambulance Service log noted an injury to his head.

In the early hours of the following morning the police received a call to say that Terry had confessed to his brother and parents to being involved in the death of someone and a fire at the location. He said they had been having bondage sex whilst both were high on drugs. During sex Terry says the victim revealed his HIV positive status which infuriated him. Terry stated that the victim began to convulse but he did not seek medical help. Terry then set fire to the property and left by taking the keys and car belonging to the owner of the flat.

Terry revealed the situation to his family members who urged him to contact the police, and he was subsequently arrested after admitting a role in Anthony's death.

The medical and forensic evidence suggested that Anthony was not alive at the time of the fire. He had a 'clean cut linear wound' but no evidence of traumatic brain injury and low-grade HIV encephalitis, not thought to have contributed to his death.

It was not possible to formulate a cause of death due to complications from burning and other factors. The Pathologist is noted to have said that bondage equipment was present at the scene and that consideration should be given to the possibility that a device or restraint was placed around the neck or he had suffered from positional asphyxia, but this was not able to be confirmed.

The post mortem report stated that there was no alcohol detected in the victim's blood or urine at the time of death but there was toxicology evidence of medicinal and illicit drugs. There was no evidence that any drug in isolation or combination could have accounted for his death.

There was no Coroner's inquest or inquiry as the local Coroner decided that the full facts of the case had been examined during the criminal trial. The owner of the apartment was away at the time of Anthony's death. There were no other members of the household.

The victim had never lived with the perpetrator but had known him for several months and had been engaged in an intimate, apparently casual, sexual relationship for several weeks. Terry was subsequently charged with murder but later pleaded guilty to Anthony's manslaughter, arson with intent to endanger life, and a number of other offences. At interview with Thames Valley Police, the IMR states that the perpetrator, Terry, said that he had been having bondage sex with Anthony while both were high on drugs (chemsex). Anthony had taken 'G' which is a type of date rape drug. During sex Anthony told Terry that he had HIV and Terry was furious. Anthony began to convulse, and Terry did not seek

medical assistance. Terry says he threw a duvet over Anthony as he was making a lot of noise. Following the death, Terry set fire to the flat in order to destroy evidence and took the car belonging to the owner of the flat.

These offences included theft, fraud, taking a vehicle without authority, arson related to Anthony's car, and possession of classes B and C controlled drugs. He was sentenced to 9 years 9 months imprisonment and an extended licence period of 4 years.

4.1 CHRONOLOGY OF EVENTS

4.1.2 Thames Valley Police IMR

The victim of the homicide, Anthony, was not known to Thames Valley Police (TVP), or any other statutory enforcement agency. He had some health issues since birth and had been diagnosed with HIV but had not visited his GP for the past 12 months. There was evidence that he had been a recreational drug user, including GHB for the past 18 months.

The TVP IMR records one of their witnesses stating that Terry did not know about Anthony's HIV status, and when the perpetrator had seen some medication he had denied it. A conversation had ensued with the witness and the victim about how he should tell Terry about his status. According to the IMR the relationship had been strained the week before Anthony's death, with Anthony having difficulty contacting Terry. One of the police witnesses, Colin, (a pseudonym) described Terry as becoming 'pushy' in a sexual way towards the victim in the last weeks of his life.

No reports or disclosures of domestic abuse have come to light in the course of this Review to any of the agencies approached.

Within the dates relating to the Terms of Reference (ToR), Terry had a warning for mental health applied to his PNC record and four entries are shown since 2 January 2015. These entries included a number of theft offences but nothing relating to violence or abusive relationship issues. Some issues did come to light following his arrest for the fatal incident, including a suspected 'date rape' drug report, shortly before the fatal incident and an attack on his younger brother several years before. This is outlined further in 4.1.3 below.

As far as is possible to ascertain, there had not been any domestic abuse related disclosures prior to Anthony's death relating to either the victim or the perpetrator.

4.1.3 Northamptonshire Police IMR

This IMR shows that Terry's family reside within the Northamptonshire area, which borders on to the TVP police area. He had been back to live with them for various periods during the past five years. From the IMR it seems that he had returned from time to time when he had been 'thrown out' of his ex-partner's home, and more permanently when the relationship broke up in 2014. Moving back to the family home was said to cause tensions. Prior to the period covered by the Terms of Reference (ToR), in 2006, the police had been called to intervene when Terry had attacked a younger brother with a metal bar. Terry was aged 16

at this time, and details of the incident are included below, although it is outside of the ToR timeline.

The police record also shows a number of times more recently when Terry came to their attention.

- In June 2009 Terry was refusing to leave the apartment of a partner and during subsequent heated argument the police were later called around removal of belongings. Recorded as Domestic Incident – Non-Crime' (two calls in total). A DASH risk assessment was completed and graded as 'standard' risk.

- During September – December 2014 another break-up with another partner also resulted in two calls to the police regarding heated confrontations and removal of possessions. No DASH risk assessment recorded.

- In January 2015 Terry was arrested and received a caution for possession of a Class A drug (cocaine) and possession of an offensive weapon (a baton found in his car). He said he was upset over the break-up of a relationship.

- In March 2015 Terry was arrested and subsequently charged with the burglary of possessions to the value of £45,000 from his former partner's address. This former partner also disclosed an assault requiring stitches three years previously which had been caused by Terry. A DASH risk assessment was completed and rated as 'standard'.

Subsequent to Anthony's death, the record shows that a previous sexual partner (Martin) was discovered to have met Terry via a dating site and had found himself unusually affected by champagne to the extent that he had woken up in the afternoon having no memory of the previous evening.

4.1.4 Anthony's GP Practice

Anthony's GP practice originally said they had no record of his attendance. They subsequently supplied information of his visits to the 'out of hours' primary care service.

He had three visits to medical practitioners between January 2012 and March 2013. Two were for minor illnesses such as flu like symptoms and vomiting and diarrhoea and on a third occasion he was diagnosed with tonsillitis and given antibiotics.

4.1.5 Terry's GP Practice

Between the beginning of January 2015 and the end of April, Terry had been attending his GP's surgery fairly regularly, around every two to four weeks. He was usually accompanied by his mother to these appointments, and she sometimes waited outside the consulting room, but on other occasions talked to the GP with her son. The IMR records questions about his mood, feelings, home circumstances and potential for self-harm.

On 5 January 2014 he had an appointment with the GP, accompanied by his mother, where he was noted to be suffering from 'low mood, asking for help, down and tearful, occasional

suicidal thoughts, and suffering from mood swings'. The notes say that he had been suffering from these mood swings for years, since childhood, and the break-up of his relationship last year seeming to have been a 'trigger'. According to the IMR the notes do not show any questions were asked about safety in terms of relationships. There are questions and responses relating to Terry's threat to himself in terms of suicide ideation.

There is a wealth of detail in the IMR about the effects on Terry of the recent break-up of a five-year relationship in 2014 and his inability to obtain employment. There is no mention of any questions around safety in that relationship. He had recently moved back into the family home, presumably due to the end of this relationship. Texts and contact from his ex-partner via Facebook and other social media were also causing him some distress. These issues are mentioned in the medical notes on a number of occasions.

He was diagnosed with adjustment disorder related to having broken up from a long -term partner and a mood disorder diagnosis with a question mark around chronic depression.

4.1.6 Terry's prescription for Citalopram (20 mg) was renewed on 5 January 2015, and 'a long consultation' was suggested which took place on 6 January with the same GP/ Clinical Practitioner. By the 16 January things seemed to be improving and by 3 February was recorded to be 'making good progress'. It is later noted, on 28 April 2015 (months before Anthony's death) that Terry was 'on a charge of burglary and due to attend court in mid-May 2015, this apparently occurred while he was under the influence of drugs – he took them with alcohol after a row.'

The GP notes that 'he regrets the behaviour, has no memory of the burglary, is still taking Citalopram, and still working at his job'. The diagnosis was 'stress-related problem' and 'depressive disorder' and the plan was to continue with citalopram and a wellbeing referral would be chased up. According to Terry's mother this was being constantly chased but there is no record of it in the IMR.

The following is beyond the timescale of the Terms of Reference but the DHR Panel and Chair have deemed it relevant. The reason for this is that it shows that in the past Terry had been aggressive towards people in his household.

4.1.7 From around 2006 (which is outside of the ToR of this Review) Terry had been recorded as presenting with irritability and anger, anxiety and depression and behavioural problems. It is mentioned in the IMR that Northamptonshire Police had attended the family home in April 2006 when he had hit his brother, causing bruising, and the next month had taken his mother's car without permission and crashed it into another parked car.

His medical records show that in August 2007 he was 'irritable and angry' – he is now aged 18 and attends the surgery with his mother. He is noted to be 'feeling very angry lately – aggressive towards his brother and mother (verbally)'. On 3 March, 2008 he came to the surgery with an auntie saying he has been 'losing control of himself and being aggressive and sometimes violent'. He 'cannot control his reactions' and is 'no longer staying with parents'. On this occasion he was referred to CMHT and prescribed Lorazepam. On 7 March, four days later, he sees the same GP and reports that for 'several years he has been short tempered with sudden mood swings and anger, unable to control himself, physically aggressive with his two younger brothers, and mother's partner. Mother afraid he can harm other people at home and the GP agrees to write a letter to see if they can make an application for housing to the Council and to check that CMHT is seeing him'. On 10 March the surgery receives a letter from CMHT saying that Terry 'does not meet the criteria for referral'.

On 4 April 2008 he is prescribed further anti-depressants. There is then a period of little medical agency contact for two years, when on 25 and 26 March 2010 he presents at the out of hours service saying he is not sleeping and is taking Temazapam, but he says he has become tolerant to it, he has not been sleeping for five days, has 'a lot of issues plaguing him, causing him anxiety /depression' and is advised to book an appointment with his GP.

There is no record of any of the GPs asking him whether his anger or mood swings was an ongoing problem in his current or previous intimate partner relationships.

5. Evidence from interviews and discussions

5.1 Interviews and meetings with Anthony's family

Anthony was obviously a special person and a much-loved part of their close and supportive family. At the meeting with the DHR Panel Anthony's mother and his older sister made it clear that the loss of their son and brother has had a severe and lasting impact upon the family. Anthony was the youngest of the siblings and a really lovely, happy person. The family expressed a desire to help with the DHR process in order to help prevent future similar tragedies.

The Chair met with the family on two occasions at the home of Anthony's mother. The first meeting was with the wider family, including Anthony's mother, sisters and aunt and uncle.

The second meeting was a more focussed interview, lasting for an hour, with his mother and older sister. At this second meeting Anthony's mother and sister agreed to come to meet the Panel members and answer their questions.

As a result of these meetings the Panel discovered that Anthony was obviously a well loved and cared for son, brother, uncle and nephew. He had a successful career as a hairdresser, salon manager and co-proprietor. He was well liked and respected in the local area. His family does not seem to have had any issues with his sexuality; they knew that he was gay and were comfortable with this aspect of his life. They had been introduced to previous partners in his life. They had not met the perpetrator prior to his death, which made them think the perpetrator was not a 'serious' relationship. It did not seem, from the discussions with his family, that he was considered vulnerable or a victim in any other relationship. Anthony's mother said that she thought that the relationship with Terry had not been 'serious' as she had not met him, whereas in other cases new partners/ boyfriends had been introduced.

Subsequent to the criminal trial, Anthony's family released a statement to the press, with the local newspaper reporting:

'**We will never truly know what happened to Anthony on that day. It's something that will haunt us forever. We now begin our life sentence without Anthony. A huge thank you to the police, family, friends, Anthony's friends, our employers and work colleagues for your support throughout this horrific nightmare and for your continued support'**

During an interview with the Chair (LW) Anthony's mother explained how they had been for a restorative justice meeting with the perpetrator in prison in order to seek some answers. Anthony's mother explained that, as might be expected, they wanted to know what had happened in the last moments of their loved one's life, most particularly, why the tragic events had happened. This meeting seemed to be largely unsatisfactory from the family's point of view because Terry would or could not answer their questions fully. In Anthony's mother's opinion Terry was still not accepting blame fully for her son's death.

5.2 Interview with Terry and Naomi (the perpetrator and his mother)

During the interview, with Terry and his mother Naomi, with two female Offender Managers present, the Chair asked a series of questions, the topics of which she had consulted with the Panel. She also gave an outline to Naomi on the phone as to the sort of areas that would be covered.

5.2.1 Analysis of the main points discussed with Terry and Naomi:

The meeting was held in one of the prison education rooms early on a Monday morning. The atmosphere was relaxed, but Terry was said to be feeling nervous, according to his offender manager. Terry's mother, Naomi had said she was worried about revealing any details that might cause more hurt or harm to Anthony's family.

After initial introductions and ice breakers the questions were put to Terry, beginning with how he met Anthony, background to the relationship, and so on.

He says they had met through Colin, Anthony's best friend. Terry had joined a social group which revolved around parties, drugs and casual sex. He wasn't particularly attracted to Anthony and he was in a situation that was not exactly friendship, but not exactly a relationship.

When asked who could have helped to prevent it escalating into the fatal event, Terry explained he was in a state of deteriorating mental health in the months leading up to Anthony's death. This had begun following the break-up of a five-year long-term relationship. Terry's ex-partner was a more experienced and financially assured man several years older than him. They had begun the relationship when Terry was in his teens and had involved the 'high life' of nice cars, flights. He was treated to holidays and luxury hotels. Once the relationship ended, Terry was 'dropped' suddenly, and it seems that his serious problems began from there. He explained he had become disorganised and missed an important flight to the US for a family wedding. At his lowest point he was ejected from Oasis House (a local homeless centre in Northampton) for 'kicking off'. He says he went to a local mental health facility asking to be 'sectioned' and was threatening to end his life.

He was arrested on New Year's night, but because Terry has a supportive family and a mother who was prepared to help him, he was released into her care. They then tried to access the 'right channels' by going to their GP, together, and talking about Terry's problems. Weekly GP appointments followed (recorded in chronology) and Terry said GP 1 at the surgery was especially helpful. According to Terry and Naomi, this doctor made extreme efforts to obtain a referral for Terry with mental health specialists, including a note in the IMR in October 2014 to seek a referral to the Well-Being Team. This had been a problem since at least 2008 when Terry had presented with 'anxiety and depression', and 'frustration and anger' being 'unable to control his reactions'. A note was made in March 2008 that he agreed to be referred to the CMHT but then a subsequent entry notes that the 'surgery received a letter from CMHT stating patient does not meet the criteria for the referral'.

His regular appointments at the surgery, sometimes as often as weekly record his depressed and anxious state. The notes show there was a chase up fax to the Well-being Team about Terry's appointment in late April 2015. This was about a month before the fatal incident. According to Terry he did not actually get an appointment to see a mental health specialist until the actual day of the fatal incident, which was, obviously, tragically too late. Whilst waiting for an appointment with the mental health team he was given medication by the GP and time to talk but then this doctor left the practice and he saw a series of others. Terry and Naomi said that they thought he might be suffering from bipolar syndrome but needed the referral to a psychiatrist to confirm or deny this and to obtain suitable medication. This is mentioned in the IMR relating to Terry's medical records in January 2015.

In the two weeks leading up to the fatal event it seems that things went from bad to worse. During this time Terry described himself as a 'functioning drug user' but feeling 'really bad

emotionally' with mood fluctuations due to uppers and downers and 'mixing it' with prescription and street drugs.

During this period of time, ie in the months leading up to the fatal incident, he said he was suspected of displaying symptoms of manic depression, but it was over a year to get an appointment to see a psychiatrist to obtain drugs to control his symptoms. He was subsequently arrested for breaking into his ex-partner's residence and taking property worth thousands of pounds. His mother asked the lead detective if she could be informed when he was going to be released on bail so that she could pick him up, as, in her words 'he wasn't well'. This was later denied by the police officer.

Terry's mother had been very worried during this two-week period because she hadn't heard from him. She contacted the police, but they said they couldn't tell her where he was because he was an 'adult'. She protested that she had recently acted as his 'responsible adult' during an interview and said. 'Please let me be there', but then she found out he had been released from custody, in a strange town, as Terry said, 'without a phone or a penny in my pocket'. Whilst this was going on, two weeks before the fatal incident, Terry's mother had protested to the police that 'He will hurt himself or we'll find him dead in a ditch somewhere'. This was subsequently the subject of an official complaint but was not deemed to be the fault of any police officer.

Moving on to the advice he would give to his former self, or to someone in a similar situation Terry said it was to 'talk to your nearest and dearest' and the people you love. Young men don't deal well with emotions, and at school no lessons cover it. Being in a relationship from 19 to 25, at the end of it he didn't know how to deal with it. Having now done a lot of therapy and working in the prison as an advocate of restorative justice, he sees he needed to learn how to deal with relationships.

This DHR also makes recommendations about the use and timings of restorative justice meetings in this type of case.

5.2.2 Interview with Anthony's best friend

The Chair met with a man who self-identified as Anthony's best friend, at his home which they had shared at one point. Colin and Anthony had known each other for about ten years. Colin says he had seen the relationship between Anthony and Terry develop and he was worried at various levels for his friend. Specifically, he had seen the perpetrator being aggressive and controlling towards the victim. He was not specific about any particular incidents; he said that there was drug taking involved on occasions.

One of the ways he illustrated his worries was to say that he had asked Anthony not to see Terry alone at his apartment whilst he was away on a planned forthcoming weekend abroad. This was the weekend of the fatal incident. Colin had suggested that Anthony should go to stay with his mum for the weekend in case Terry became difficult. Colin was aware of the situation with Anthony's non-disclosed HIV status and the trouble it might cause if discovered. He was suspicious of Terry and felt he told them lots of lies.

Despite Colin's worries that the tragic event had taken place due to his introducing the pair and he had suspicions about Terry there is no blame attached to his actions. He knew about Anthony's undisclosed HIV status and he was going away for the weekend but he has nothing to reproach himself for as he could not foresee what was going to occur.

The information Colin provided at the interview was already known to TVP and has been explored in the police IMR and chronology. He confirmed what he had said to the police and that he very much regretted, and was sad about, Anthony's death. Asked if there was anything he would have done differently he said not because he did not think the threat was serious enough to take action. If it had been, he said, he was not sure how the police might have viewed their 'lifestyle' given that they were gay men and drug users. When asked if he knew about the right to ask questions about a previous partner's behaviour, commonly known as 'Clare's Law' he said he did not think he would have seen it as relevant to men. This issue is discussed in the Conclusion section of this Review.

6. **OVERVIEW**

6.1 It seems that very little was known by any statutory or third sector agencies about Anthony, the victim of this homicide. He appears to have been popular and to have led a full social life, both in terms of social media and local pubs and clubs. He has posts on social media as far back as 2008 showing him with friends at the local gay and lesbian venue. He had not come to the attention of the police or any other statutory agencies other than a limited contact with his GP. He was part of the gay scene in the area and enjoyed having friends and relationships within that group. Further, Anthony does not seem to have had any problems regarding his sexuality or relationships in the past. His family knew he was gay from an early age. He was posting on social media from the local gay club and other venues. His family said he was a social 'sofa surfer' and they often did not see him for a couple of weeks. He worked in a local hairdressing salon as co-owner and trainer. He was well liked by customers and in the local community.

6.2 Unlike Anthony, the perpetrator, Terry, had some recorded contacts with the police, with relevant events quite near to the time of the fatal incident. These included being found with illegal drugs, allegations of taking a car without the owner's consent and suspicion of burglary. There is also a long list of medical notes recorded on the IMR outlining visits to the GP regarding Terry's mental health.

These entries begin on 3 February 2015, where Terry's GP noted that he has been suffering from mental health issues including a depressive disorder for which he has been 'referred on' for other talking therapy help. On another occasion (1 April 2015) another GP in the practice noted that he had ongoing problems with depression for the past six months, that he had managed to stop using recreational drugs and that he should increase his medication and see him again in four weeks. He was said to be depressed due to the break-up of a long-term relationship.

The evidence from the IMRs is backed up by the interviews and discussions presented here in this Overview Report. It seems that this was a short term, casual relationship, between

two adult males, that involved sex and illicit drug use – sometimes termed 'chem-sex'. Terry has admitted manslaughter as he did not take steps that might have helped to save Anthony. Anthony was clearly a well-liked and loved man who enjoyed life and led a different lifestyle. His older sister made a comment along the lines of 'he'd come back home when he needed something' but was otherwise assumed to be having fun, working and leading a fulfilling social life. Colin described him as a little bit vulnerable and 'looking for love'. Perhaps this does indicate that Anthony was potentially vulnerable.

6.3 Anthony met Terry when he was still grieving and hurting from the break-up of a long-term relationship. His life with this older, influential man seems to have been incredibly happy, fun and all-consuming. At the time of the fatal incident Terry was taking prescription and illicit drugs and could have been suffering from a cycle of grief which made him, in professional parlance, 'low and angry'. In his interview with the Chair of the DHR in prison he explained he felt unable to talk about his feelings at that time. Terry's mother says she was so worried, in the lead up to Anthony's death, that she was constantly phoning the police and Terry's friends to try to find him. She felt he might do something terrible to himself or others. Just prior to the fatal incident, when Terry was arrested on another matter, she asked to be told when he was released or at least where he was, but the police said they could not tell her as 'he is an adult'. The perpetrator's mother subsequently made an official complaint about not being contacted when he was released from custody, even though she says she had talked to the lead detective by phone. The police investigated her complaint but found there was no case to answer.

7. **ANALYSIS**

7.1 The death of a male victim of a domestic homicide is currently less common than for female victims in England and Wales. There are approximately 2 female victims losing their lives in domestic circumstances each week, as opposed to one male victim. ONS data on victim or perpetrator sexual orientation is not freely available so it is difficult to locate this case in a wider picture of abuse leading to fatalities. The Homicide Index does not record sexual orientation.

In the year 2014 - 2015, around the time of Anthony's death, there were 50 male and 107 female domestic homicide victims (which includes intimate partner homicides and familial homicides) aged 16 and over (Home Office 2016, p.3). Of these, the Homicide Index for that year showed that 83 suspects of current or ex-partner perpetrators were male (Home Office 2016, p. 36).

The number of male victims of male perpetrators in domestic situations is not currently recorded but it would seem, given the numbers of women killed in comparison to men, that it is relatively rare. In 2016 -17 for example, according to Mankind, an organisation campaigning on behalf of men, 13 men died at the hands of their partner or ex-partner compared to 82 women (Mankind Initiative 2018). The most recent figures, available in 2019 for the year ending March 2018 show further reductions, as the ONS data suggests:

There were large differences in the victim-suspect relationship between men and

*women. A third of women were killed by their partner or ex-partner (33%, 63 homicides) in the year ending March 2018. This is the fewest number of women aged 16 years and over killed by a partner or ex-partner in the last 40 years, although this may change as police investigations continue and the Homicide Index is updated. In contrast, only 1% of male victims aged 16 years or over were killed by their partner or ex-partner (**seven homicides**) (ONS, 2019, p10)*

Despite these small numbers of this type of homicide, research on male victims of partner abuse suggests that men are much less likely to report incidences of domestic abuse, and they say that from their research in 2018:

Male victims (39%) are over three times as likely as women (12%) not to tell anyone about the partner abuse they are suffering from. Only 10% of male victims will tell the police (26% women), only 23% will tell a person in an official position (43% women) and only 11% (23% women) will tell a health professional (Mankind 2018, p.3).

Despite this, they argue that gay men and lesbian women are more at risk of abuse:

The percentage of gay or bi-sexual men (6.2%) who suffered partner abuse in 2008/09 is nearly double the number for heterosexual men (3.3%). Lesbian women (12.4%) as a percentage also suffered far more partner abuse compared to heterosexual women (4.3%). (Mankind Initiative 2018, p.3)

They go on to argue that only a very small percentage of men who report domestic abuse are in same sex relationships.

As *reported by the Scottish Government, 6.6% of male victims of partner abuse are victims at the hands of men as they are in a same-sex relationship. In terms of reporting to Scottish police, one in ten men who report as being a victim of domestic abuse state that the perpetrator is also a man. In Scotland, 20% of victims who report to the police in Scotland are male, 2% of victims are men who are victims* at the hands of other men (Mankind Initiative 2018, p.4).

This might indicate that this sort of abuse is very rare, or that men feel unwilling to report it. More research would be helpful in this area.

7.2 In terms of relevant academic research in the area, one of the only substantive type of study is the work that is conducted on male-on-male homicides where the victim and perpetrator were friends. These cases usually involve confrontations, fights and a social scene involving bystanders or friends and acquaintances. As Polk suggests, in male on male homicide:

To summarise, this form of homicide involves behaviour which is essentially a contest of honour between males. In the initial stages of the encounter, what the participants in a confrontational killing intend is first to argue, then to fight…The lethal violence is not pre-meditated, at least not at the starting point of the conflict (Polk 1994, p. 91).

A more recent text, by the domestic abuse experts, Dobash and Dobash published in 2020, shows that whilst not common, what they describe as 'male-male murder' can take many forms. They discuss some similar types of events to those leading up to Antony's death, although it is difficult to draw conclusions or parallels with any of their cases because there are different versions of what happened and the facts are still unclear.

Analysis relating to research in this case is made especially difficult because despite the best efforts of all the agencies involved, it is not completely clear as to why the events occurred leading to Anthony's death. The verdict of the court was manslaughter but Terry has stated he cannot remember what happened. The victim and perpetrator had a short-term intimate partner relationship, of only a few weeks duration,

The victim's self-identifying best friend, Colin, had been worried about the dynamics of the relationship and had warned the victim that he thought Terry could be dangerous. He regrets that he was not in a situation to help the victim when the circumstances leading to his death occurred, as he was abroad when the events happened. When he was interviewed about this by the Chair, he said he did not think that he would have been likely to call any outside agency, such as the police, as it had not been serious enough to concern them in the past. He was also worried about involving the police in case they asked about illegal drug taking. He says he had once had to threaten to make Terry leave a party one evening, but as he then complied with what he was asking, no further action was warranted.

Similarly, regarding the alleged 'date rape' drug incident, mentioned in the Northamptonshire Police IMR (section 4.1.3 above), prior to the fatal incident, the victim did not feel it serious enough to contact the police. It is not suggested that the police could or should have taken any action, as they were not aware of the incident prior to their investigations into Anthony's death.

7.3 How were the Terms of Reference addressed by this Review?

i) Any incidents or disclosures involving violence and abuse

The ToR were addressed by examining the background to the relationship, its progress and whether any disclosures of domestic abuse were made to anyone. There seems little evidence of ongoing domestic abuse, either physical or psychological other than the isolated instance of aggressive and controlling behaviour mentioned by Anthony's friend, Colin. All of the people consulted for the Review, including the family of the victim and the perpetrator, state this was a short-term relationship which seems to have been based on casual sex.

There does not seem to be anything obvious that could have made a difference to have prevented the tragic outcome. As domestic abuse is an under-reported crime in heterosexual relationships, it is to be assumed, in the absence of any substantive evidence, that this is also the case in same sex partnerships. There was some difficulty in securing LGBT representation on the DHR Panel, as we were relying upon a volunteer organisation which did not necessarily have the capacity to fulfil the time commitment required.

ii) References to the misuse of alcohol and drugs

The so-called ‘toxic trio’ of Mental Ill-Health, Substance Misuse and Domestic Abuse is apparent in this case.

It could be argued that patients presenting at GP practices who display such symptoms, would benefit from being asked further details in respect of screening questions on safety, for self and others. This term is sometimes seen as obscuring the fact that domestic abuse is often the root-cause of mental ill-health and substance abuse. This makes a co-ordinated response to the issue even more important.

Being asked questions about the safety of self and others when presenting with one of the other two issues (mental ill-health and substance abuse) could be questions that may be required of the GP practices, and could be a suggestion for further training.

iii) Health related issues

Prior to the fatal incident there was little any agency knew about Anthony, the victim. There was escalating evidence that Terry was suffering from mental health problems, but not indication he was likely to be a danger to others in a relationship. No threats had been made, or disclosures of domestic abuse to the GP, although his mother was clearly very worried about his mental state. As Terry was an adult however, her role was not always employed to the full, as she claimed she was treated like an over-protective ‘neurotic mother’.

iv) The engagement and offering of services and support

In terms of engagement and the offering of support, there does seem to be a lack of LGBT services in the Milton Keynes area, at least at the time of the tragic event. This is partly evidenced by the way the Council had difficulties accessing any of the community’s members to take part in the DHR Panel. The victim’s friend said he would not have known who to approach even if he wanted to alert someone to the potential danger he thought Terry might pose. This might be because he was unsure about the police taking male victims of domestic violence seriously, LGBT services being available or knowledge of other services, such as health care or counselling.

From his detailed notes it seems that Terry’s GP was focussed on mental health issues relating to the breakup of his relationship but did not appear to question, or be curious about, the potential complications of being a gay man with anger issues in his adolescence.

Prior to the fatal incident there was little any agency knew about Anthony, the victim and so there is little that can be said about engagement, the offering of services and support. There were few details about Anthony’s medical condition in his notes, or being HIV positive, although he was receiving treatment and medication. It may be that these details were not recorded, but help and advice about disclosing HIV status to new partners could be a useful conversation for GPs to initiate.

7.4 Examples of good practice

Some examples of good practice have been indicated by Anthony's family regarding the TVP officers and especially the Family Liaison Officers. The officers with whom they came into contact dealt with the family in a manner which was respectful and empathetic. Anthony's mother commended them for breaking the news of her son's death sensitively, and also for telling them everything that they asked about, 'at every step' of the process.

In addition, the GP at Terry's practice whom his family said was 'absolutely brilliant' and worked very hard to try to obtain an appointment with a specialist mental health team. Terry's mother also said that the police dealt with them at the time of the fatal incident, with respect and professionalism.

8. **CONCLUSIONS**

8.1 The main issues identified here are that this was a tragic death but it was impossible to predict. Although Anthony had been using a dating site he met Terry through other avenues. It does not appear that there should be any advice or lessons to be learnt about taking precautions around danger and meeting strangers as they had known each other for a while prior to the events leading to his death.

8.2 Regarding the role of Colin, he had clearly had some misgivings about Terry, and had advised Anthony to be careful, including advice around the disclosure of his HIV status. As he explains however, he did not feel any behaviour he witnessed or worried about was serious enough to warrant any further intervention, although with hindsight, he clearly regrets not taking further steps. In addition, he was worried that the police might suspect people were using illegal drugs and so he would have been unwilling to call them.

8.3 Terry's GP practice was treating him for depressive symptoms and seems to have been taking all reasonable steps to help him. There does not seem to be anything in his recent medical notes to suggest potential for violence or aggression within the dates of the terms of reference. There had, however outside of these dates, been some previous history of violence towards a family member. It was also noted, in 2014, some reluctance to take medication for his sleep problems, perhaps suggesting he was not engaging with the GP. There was also a note in the GP's records to indicate evidence of mood swings, and a history of aggressive behaviour. With hindsight, these may have been a signal, combined with other symptoms, that there were mental health issues that were not being addressed appropriately.

9. **LESSONS TO BE LEARNT**

In view of the findings of this Overview Report it is difficult to suggest any lessons to be learnt which are drawn directly from Anthony's death. This is because there was little evidence of domestic abuse, few relevant contacts with agencies and uncertainty as to how Anthony died.

There was some suggestion, in the TVP IMR, that the fatal incident may have occurred due to Terry discovering Antony's HIV status. A potential lesson could include the encouragement for local professionals to continue to be curious and supportive of people who might be struggling with a diagnosis of HIV and how this might be revealed to potential sexual partners.

Sadly, neither of these would have necessarily made a difference leading up to Anthony's sad loss, as neither could be predicted in this case. The findings of this Review should be shared with police and health professionals, as in the future it could be worth emphasising the circumstances of Anthony's death to professionals in case similar ones arise.

On a more general note, it would be helpful if SaferMK, and Milton Keynes Council more widely, could endeavour to develop relationships with local LGBT+ organisations and

communities. This could lead to a better understanding of the needs of these groups and a potential pool of Panel members who could assist in future DHRs.

10. **RECOMMENDATIONS**

At present there are no obvious recommendations arising from this Review regarding the inactivity of specific agencies, although some discussion might be appropriate regarding lessons to be learnt around the following issues:

- There seems to be a problem with people with ongoing / recurring mental health issues relating to previous episodes of aggression and the time it takes to get an appointment. This Review acknowledges the difficult ongoing funding situation but suggests there could be more community-based interventions created in order to alleviate this problem.

- This Review makes general recommendations regarding agencies' approach to the use of recreational drug use and the reporting of coercive control. Methods should be found to publicise ways in which people using illegal drugs can approach agencies about domestic abuse without fear of disclosures about illegal drugs being reported. This may involve local voluntary/ third sector groups.

- Local GP services could also be made more aware of the possibility of domestic abuse and be trained to ask about it. People presenting with mental health issues, or with grief at the end of a relationship, could be masking other problems. Some sort of training such as IRIS or similar would be helpful in this regard.

- The victim's GP surgery seemed unaware of the statutory nature of the DHR process. Despite numerous calls and emails, they did not provide an IMR. Finally, the DHR Chair had to visit the surgery in person to emphasise to the Practice Manager that their cooperation was needed. It would be helpful to have some sort of education process to enlighten local practices of the process.

- In addition, this DHR was severely delayed by one of the perpetrator's Offender Managers, at the prison, being unaware of the DHR process. More than twelve months was wasted in negotiations over access. More awareness of the DHR process would be helpful here.

- More generally there could be awareness-raising in regard to LGBT communities around Milton Keynes and domestic abuse. Organisations such as *Stonewall* and *Safelives* have some limited information available, but the whole issue regarding domestic abuse in LGBT+ communities merits further research.

- *SaferMK* could endeavour to seek out local LGBT+ communities and organisations to examine their needs and wishes and, potentially, to encourage their participation in future DHRs concerning victims with alternative sexualities.

Specifically:

- This Review recommends that there could be more information about coercive control in the public domain around same sex relationships. Anthony's friend felt there was

something wrong and was worried about his safety, but didn't feel there was any evidence of physical violence.

- It further recommends around advice disclosing HIV status to new partners. This could be facilitated by GPs and specialist HIV health providers, using this DHR as a case study. A specialist publication or website could be developed to suggest safe ways to carry out these disclosures.

- It makes a recommendation around 'date rape' type drugs and the use of dating sites. Although Anthony's death and this Review did not involve a dating site directly, there were suggestions that other, potentially dangerous events, were revealed in the course of the Review.

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