CONFIDENTIAL

OVERVIEW REPORT

DOMESTIC HOMICIDE REVIEW

in respect of

DHR 9, 2015

Deceased June 2015
Age 46 years

Beverley Czyz
August 2017

CONFIDENTIAL

Contents

1. INTRODUCTION

1.1 Domestic Homicide Reviews were introduced by the Domestic Violence, Crime and Victims Act (2004), section 9.

1.2 A duty on a relevant Community Safety Partnership to undertake Domestic Homicide Reviews was implemented by the Home Office through statutory guidance in April 2011. The 'Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews' was updated in August 2013 and that revision provided the framework within which this Review was conducted[1].

1.3 A Domestic Homicide Review (DHR) is defined[2] as:

A review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by:

- a person to whom he was related or with whom he was or had been in an intimate personal relationship, or
- a member of the same household as himself,

held with a view to identifying the lessons to be learnt from the death.

1.4 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 policies and procedures as appropriate; and
- Prevent domestic violence homicide and improve service responses for all domestic violence victims and their children through improved intra and inter-agency working.

1.5 DHRs are not inquiries into how the victim died or into who is culpable; that is a matter for Coroners and criminal courts. They are also not specifically part of any disciplinary enquiry or process; or part of the process for managing operational responses to the safeguarding or other needs of individuals. These are the responsibility of agencies working within existing policies and procedural frameworks.

1.6 In accordance with statutory guidance the findings of each review are confidential as this information is available only to participating officers, professionals and their line managers. While all areas of the statutory guidance have been considered, confidentiality requirements mean that some information considered and lines of enquiry taken by the Panel are not detailed in the report.

[1] www.homeoffice.gov.uk.
[2] Domestic Violence, Crime and Victims Act (2004), section 9 (1).

Summary of Circumstances Leading to the Review

1.7 The victim P and the perpetrator Q were half-siblings and previously had resided together as members of the same household in Stoke-on-Trent. Both were known to agencies in Stoke-on-Trent.

1.8 In June 2015 Q reported to the Police that he had found P deceased at her address. A murder investigation was commenced by the Police. Q was one of a number of persons initially detained as part of that investigation and subsequently released.

1.9 Two days after the fatal incident, Q returned to a custody facility in Stoke-on-Trent when he informed officers that he wanted to admit to murder. Q was arrested again and subsequently charged with the murder of P.

1.10 On 19 August 2015, a Scoping Panel convened on behalf of the Stoke-on-Trent Responsible Authorities Group considered the circumstances of the case and concluded that the criteria for conducting a Domestic Homicide Review were met. A recommendation to commission a Domestic Homicide Review was endorsed by the Chair of the Responsible Authorities Group through the agreed process.

1.11 Q pleaded guilty to P's murder at Crown Court in September 2015 and was sentenced in November 2015 to life imprisonment.

Terms of Reference

1.12 The full Terms of Reference for this Review are at Appendix A. The following is a summary of the key points.

1.13 The Review considered in detail the period from 1 May 2012 (four days prior to when Q first attended Accident and Emergency in Sunderland following a relationship breakdown) until the time of the fatal incident, with the exception of the National Probation Service, where the period commenced from 20 March 2006 (when the perpetrator was sentenced to 54 months' imprisonment for wounding) until the time of the fatal incident.

1.14 The focus of the Review was on the following individuals:

Name	P	Q
Relationship	Victim	Half-Sibling
Gender	Female	Male
Age (June 2015)	46 years	34 years
Ethnicity	White British	White British
Address of P:	Stoke-on-Trent	

1.15 Specific issues considered by the Review were:

- Offender management
- Mental health of the perpetrator and the effectiveness of services
- Effectiveness of response to perceived vulnerabilities.

Review Panel Chair and Independent Overview Report Author

1.16 The Review Panel was chaired by Chris Few and this report of the Review was written by Beverley Czyz, an Independent Consultant who is also a qualified social worker. Mr Few has chaired review panels and written overview reports on behalf of numerous Community Safety Partnerships, Local Safeguarding Children Boards and Local Authorities in connection with Domestic Homicide Reviews and Serious Case Reviews[3]. Ms Czyz also has substantial experience in participating in Domestic Homicide Reviews and Serious Case Reviews and has undertaken the Home Office Domestic Homicide Review accredited qualification. Neither Mr Few nor Ms Czyz has any professional connection with any of the agencies and professionals involved in the events considered by this Review.

Review Panel Members

1.17 The Review Panel comprised the following post holders:

- City Hospital Sunderland NHS Foundation Trust: Lead Nurse Patient Safety
- Gentoo (a Sunderland housing provider): Operations Manager for Community Safety and Safeguarding
- National Probation Service – North East Division: Senior Probation Officer
- National Probation Service – Staffordshire and Stoke: Head of Service Staffordshire and Stoke-on-Trent
- NHS England North Midlands (in respect of primary care services): Primary Care Quality and Safety Manager
- Northumberland Tyne and Wear NHS Foundation Trust (mental health): Head of Safeguarding and Public Protection
- Northumbria Police: Major Crime Review Advisor
- Staffordshire Police: Major Crime Policy Review and Development Team
- Stoke-on-Trent City Council – Co-operative Working (Housing Services): Operation Lead.

Review Process

1.18 In addition to the Scoping Meeting on 19 August 2015, the Review Panel met on 9 November 2015 and 30 March 2016 to consider, scrutinise and challenge contributions, emerging findings and learning from the Review.

1.19 The review process examined the history of both P and Q 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. This included consideration of equality and diversity issues as relevant to P and Q's history, lifestyle and culture.

[3] Under the Children Act (2004) and its associated statutory guidance.

1.20 The review process also considered the response from services against the procedures in place at the time and if any change to current procedures or protocol was required to prevent future harm.

1.21 This Overview Report was endorsed by the Review Panel on 7 June 2016 and forwarded to the Chair of the Stoke-on-Trent Responsible Authorities Group. On 22 July 2016, it was presented to and endorsed by the Responsible Authorities Group.

Contributions to the Review

1.22 Requests to confirm the extent of their involvement with the subjects of this Review were sent to all statutory and voluntary agencies in Stoke-on-Trent, Staffordshire and Northumbria who may potentially have had such involvement. This scoping process was used as the basis for more targeted requests for Management Review and Summary Information Reports. The Safer Sunderland Partnership provided considerable assistance in facilitating this process in respect of Northumbria organisations.

1.23 Management Review and Summary Information Reports from agencies having involvement with either P or Q were submitted by:

- A legacy substance misuse service
- City Hospitals Sunderland NHS Foundation Trust
- Gentoo (a Sunderland housing provider)
- National Probation Service (North East)
- National Probation Service (Stoke-on-Trent)
- NHS England
- North Staffordshire Combined Healthcare NHS Trust
- Northumberland Tyne and Wear NHS Foundation Trust
- Northumbria Police
- Staffordshire Police
- Stoke-on-Trent City Council Cooperative Working
- University Hospitals of North Midlands
- West Midlands Ambulance Service.

1.24 Other sources of information accessed to inform the Review included:

- An overview of domestic violence and abuse services in Stoke-on-Trent prepared by the City Council Personal Crime Programme Lead.
- Domestic homicide review: lessons learned, Home Office (2013)
- Domestic Homicide Reviews: A Staffordshire Perspective presentation prepared by Principal Community Safety Officer, Staffordshire County
- National Policing Improvement Agency (NIPA) Practice Improvement Briefing Note on The Mental Capacity Act (MCA) 2005
- Northumbria Police Protecting Vulnerable People (PVP) Policy Feb 2016
- Northumbria Police Protecting Vulnerable People (PVP) Procedure Feb 2016
- Staffordshire's Strategy for Tackling Domestic Abuse
- Stoke-on-Trent City Council's Vulnerable Children and Corporate Parenting Services.

Parallel Processes

1.25 The criminal investigation into the murder of P was conducted in parallel with this Review. In September 2015 Q pleaded guilty to murder at Crown Court and in November 2015 was sentenced to life imprisonment.

1.26 HM Coroner for Stoke-on-Trent and North Staffordshire opened and adjourned an inquest in November 2015 pending receipt of the post mortem examination report. In accordance with statutory guidance the inquest was concluded with a narrative verdict of unlawful killing based on Q's homicide conviction.

1.27 In addition, Staffordshire Police opened an investigation in November 2015 into potential offences that Q alleged had been previously committed by P. However, no viable lines of enquiry were identified and the investigation was therefore closed in February 2016.

1.28 There is also an ongoing investigation into allegations of historic intrafamilial child sexual abuse by Q. Other allegations, made in April 2012 by a fourteen-year-old boy that he had attended Q's home address and had engaged in sexual acts in return for money and cannabis are being revisited as part of this investigation. At the time of the allegation an initial account was taken from the victim and arrangements were made to conduct an Achieving Best Evidence interview. However, the victim was deemed not suitable to undertake such an interview and the decision was taken in May 2012 by the CPS to take no further action. At the time there was no intelligence or information recorded regarding any other children or potential victims.

1.29 While the Terms of Reference originally aimed to have this Review concluded by 16th February 2016 these parallel processes have required that timescale to be revised.

Family Engagement

1.30 Members of P's family were advised of the Review in January 2016, invited to contribute and were offered a meeting with the Overview Author and Review Chair. Further attempts were made to make contact with individual members of P's family by the Police Family Liaison Officer but no response was received.

1.31 Statements were taken from relatives and associates of P by the Police as part of the homicide investigation. However, these statements did not reveal anything of any relevance to this review.

1.32 Q was informed of the Domestic Homicide Review in January 2016 and was invited to contribute however he declined to engage with the review.

1.33 Although the family members did not wish to contribute to the review the Responsible Authorities Group offered sight of this report prior to its submission to the Home Office. Attempts were made to engage with the individual family members including through direct contact however they declined the opportunity to have sight of the report. The Responsible Authorities Group have also given due consideration to the support needs of family members in connection with publication of the Overview Report.

2. THE FACTS

The Victim P's Story

2.1 P was born in Stoke-on-Trent and lived the majority of her adult life there until her tragic death. P was 46 years old, white British and a mother and grandmother with a large and close extended family who lived locally. At the time of her death she had been staying with her daughter for a few weeks after moving out of her then partner's address when their long term relationship came to an end in early June 2015.

2.2 It is believed that P had been moving transiently between addresses for some time before moving to live permanently with her then partner in December 2013. This corresponds with the timeframe of when she lost the social housing tenancy she had previously held for ten years. Although during the tenancy there had been concerns around anti-social activity at the property involving her adult children and their associates the eviction was due to substantial rent arrears and P was deemed intentionally homeless.

2.3 P was not married to her ex-partner although she was often known to refer to him as her husband during their relationship. Whilst in the relationship they regularly spent periods of time travelling abroad together as the ex-partner was of retirement age. P was known to be a victim of domestic violence in 2005 and 2006 however there was no report or indication that P was a victim of domestic abuse during the period of the scope of the review.

2.4 P was one of eight children and both of her deceased parents had been alcoholics. It is believed that domestic abuse was a factor within the relationship. Both of P's parents were deceased by the time of her death. It is believed that P's parents separated for a time when P was still a child and during this time P's mother gave birth to Q who was P's half sibling. It is understood that P maintained contact with both branches of the family and considered Q and his siblings as part of her wider extended family.

2.5 Family appears to have been important to P especially her own four children who at the time of her death were all in their twenties. It was noted from the records reviewed that P's support for her family extended to seeking supporting information from her GP for her children; for example, seeking proof of her son's carer's responsibilities before a court appearance.

2.6 P was known to have an alcohol misuse problem for many years and to suffer from anxiety and depression. This according to the records appears to be linked to her concerns about becoming homeless and the consequences of her children's lifestyle.

2.7 It is known the P allowed her sons and associates to stay at her property at times and they lived a somewhat chaotic lifestyle which was known to have included substance misuse; criminal offences including criminal damage, theft, traffic offences and minor assaults including domestic abuse. The family lifestyle therefore led to P becoming embroiled in disputes with other family members, residents and associates of her children. For example, in 2011 she became embroiled in an argument that turned physical with the female ex-partner of one of her sons. Alcohol was recorded as a factor in the incident.

2.8 Although P was known to the Police as a victim of criminal damage and antisocial behaviour that often took place at her home, she herself was not known to have committed any offences. It was reported that in the majority of cases reported no further action was taken as the family tended to close ranks and people would not provide statements or give evidence against them.

2.9 Members of P's family were offered the opportunity to contribute to the review and to assist with providing the author and panel with a 'pen portrait' of P. While the family declined to be involved in the review some sense of their view of P can be drawn from the family statement made on the sentencing of Q. This simply stated that "*We have lost, in the most tragic of circumstances, the best mother, grandmother and sister that anyone could possibly have*".

Background of Q.

2.10 Q was born in 1980 and was the half-brother of P; they shared the same mother. Q is one of eight children, three full siblings and four half siblings. Q was referred to Child Guidance Clinic by the Educational Welfare Officer aged ten who reported '*many family problems and low care'*. Q had been known to Staffordshire Police in 1994 as a victim of a domestic assault

by his father (along with one of his sisters) twice that year. In 1995 he reported the alleged extrafamilial sexual abuse of another of his sisters. In 1996 aged 16 he was a victim (along with his brother) of an alleged sexual abuse by a friend of the family.

2.11 As an adult Q continued to have a troubled history as in 1999 Q was cautioned for a public order offence after being refused service when he was attempting to buy alcoholic beverage. In 2001 he was fined at court for assaulting a Constable after refusing to leave the scene of a domestic dispute with his brother. At New Year 2006 Q stabbed another family member while under the influence of alcohol and was subsequently sentenced to 54 months' imprisonment. The Judge on sentencing stated "*You have two convictions and two cautions which reveals a temper, particularly when you have drink inside you. You stabbed your brother in law and said 'Happy New Year [expletive]'. This was premeditated and you took care in the selection of the knife. On arrest you expressed disappointment that you had not killed him. I take the view that when under the influence of drink you present a significant risk.*"

2.12 In 2009, Q committed a drink drive offence and was also arrested for a domestic related assault on his then partner. The assault had resulted in minor injury to Q's partner and owing to evidential difficulties the decision was taken at the custody stage to take no further action. Alcohol was again recorded as a factor in the incident.

2.13 Q also presented as being depressed and suicidal at various times throughout his life. The first recorded occasions being in June 2001 when he was nineteen and he had two voluntary admissions in short succession on the Acute Admissions Ward. During his stay there were five violent incidents on the ward involving objects and hostility towards staff. Q at that time was diagnosed with a border line personality disorder which is noted on his discharge paperwork. This pattern of alcohol and substance misuse, self-harm and suicide idealisation without real intent to end his life; followed by episodes of being hostile and aggressive to staff continued over a number of years with the last reported hospital admission ending in November 2012.

2.14 The formative years of both P and Q appear from background information gathered to be chaotic and challenging and this lifestyle continued into their adulthood and wider relationships. Chaotic households are a term used by social workers in children's social care, stemming from serious case reviews of child deaths and abuse. Some of the characteristics which fit this case are low income, poor housing conditions, children missing education, low take up of statutory services officers, criminality, substance misuse, plus domestic abuse. Such 'chaotic families' are now better known and described through the 'Think Family' [4] Programmes. In line with this national guidance there is evidence within the scope of the review of appropriate liaison between adult facing and children's service where concerns regarding children have come to light.

Case specific background

2.15 A detailed chronology was made available to the Panel which merged the information available from the individual agencies. The following is a summary of case specifics in relation to Q

2.16 In March 2006, Q was sentenced to 54 months' imprisonment for an offence of wounding with intent. In May 2006 Q alleged that he had been sexually assaulted and requested a move of prison which was granted. A year later in May 2007 an OASys assessment was completed that assessed Q as medium risk of serious harm to known adults but also the general public, persons within a close relationship and the Police. During this assessment Medium risk to prisoners was also added.

[4] Think Family Toolkit Improving support for families at risk, Department for Children, Schools and Families (2009)

2.17 In July 2007, Q was referred to an Anger Management programme but never commenced the programme. Q was released from custody in April 2008 under the supervision of the Probation service in Stoke-on-Trent. Q attended a number of appointments before moving to Sunderland in August 2008 when his case was transferred to Northumbria Probation. In May 2009 Q made contact with the Sunderland Office to advise he was moving to Stoke-on-Trent. In June 2009 Q was transferred back to Stoke-on-Trent Probation and was living with one of his sisters.

2.18 At the end of November 2009 Q was sentenced at Fenton Magistrate's Court to a 12-month Community Order with a requirement of 100 hours unpaid work for excess alcohol and failing to report an accident. However, in early December 2009 Q confirmed that he was moving back to Sunderland that week with his partner and a request was made to Northumbria Probation to accept transfer of his licence and supervision of the new Community Order.

2.19 Q completed his 100 hours of unpaid work in early April 2010 in Sunderland and his licence expired in July 2010. Q remained in Sunderland and in June 2012 a report was received by Northumbria Police from a neighbour that she had been assaulted by Q after confronting him about a missing purse. This complaint was later dropped and no further action was taken.

2.20 Shortly thereafter in April 2012 Q was interviewed by Northumbria Police following an allegation of sexual assault by a fourteen-year-old boy. Although the case was not progressed Q reports this as a precipitating factor when he took an overdose in early May 2012. Q was admitted to the Acute Medical Unit and then discharged.

2.21 Between 5 May 2012 and 13 November 2012 Q presented at the Accident and Emergency Department having taken an overdose or indicating feelings of self-harm on several occasions. During this period, he also spent 26 days as an inpatient at Cherry Knowle Hospital. Q absconded on a number of occasions and was returned to hospital by Northumbria Police. He was also charged with criminal damage relating to his ex-partner's vehicle. In December 2012 Q became homeless and formally terminated his tenancy in Sunderland in January 2013.

2.22 In February 2013 Q's remaining unpaid work hours were transferred in to Stoke-on-Trent Probation's Unpaid Work unit. In March 2013 Q was arrested by Staffordshire Police for failing to respond to bail in Sunderland. Q was arrested in May 2013 for racially aggravated assault but no further action was taken. In June 2013 Q appeared at Sunderland Magistrates and was convicted of criminal damage and malicious damage.

2.23 Q was sentenced to a 12-month Community Order with 12 months' supervision and was again supervised by Stoke-on-Trent Probation. In June Q was staying with his brother-in-law and awaiting council accommodation. Q was subsequently advised by Vulnerable Children and Corporate Parenting that he could not remain in the property. Q remained in the property as he could not get alternative housing and his brother-in-law's contact with his children was therefore stopped.

2.24 On New Year's Eve Staffordshire Police attended an incident involving Q and his teenage nephew but no further action was required. At the end of January 2014, Q was offered a tenancy near his sister's address and he remained at this address until his arrest in June 2015.

Summary of Events

2.25 In the early hours of a Sunday morning in late June 2015 emergency services received a telephone call from Q who reported that he had found his half-sister, P dead at her home.

2.26 Staffordshire Police had attended the property where they had found P in the bathroom. P was found bent over the long side of the bath tub, face up with just her head and arms in the water and her feet over the side. It was clear that P had been placed in this position post death.

2.27 Q was in attendance at the property when Staffordshire Police arrived. P's daughter arrived immediately after, along with her partner. All three were arrested and taken in to custody and questioned. P's daughter and her partner were released with no further action and Q was released on Police bail.

2.28 Initially the investigation had considered whether the homicide had been carried out by someone known to the victim and a further arrest was made however this was later found to be irrelevant and the person was completely vindicated.

2.29 Two days after the fatal incident, Q returned to the Northern Area Custody Facility when he informed officers that he wanted to admit to murder. Q was arrested again and interviewed. At interview Q stated that he had gone to the home of his niece at around 9.00pm where he had had a meal and drank alcohol with P. They had watched a film together and he had then left the property at approximately midnight. Q then returned home, had a further alcoholic drink and formed his intent to kill P.

2.30 Q cut a strap from a backpack, changed his shoes, donned a waterproof coat and trousers and then returned to P's home. P was asleep, face down on the bed. Q put the strap around P's neck and strangled her until she became limp. Q stated that he believed P was still alive at this point as she was making gasping noises. Q then returned to his home and changed his clothes again before returning to P's home. Q then strangled P again with a plastic strap cut from a carrier bag and moved the body to the bathroom.

2.31 When interviewed by Staffordshire Police Q stated he had had thoughts of killing since he was a teenager. At the age of fourteen he alleged he had made an attempt on the life of a sibling. He also stated that in March 2015 he had dressed himself in the clothing that he had worn to kill P and had walked around with a knife looking to kill someone. He had not seen anyone on this occasion and was therefore unsuccessful. Q alleged that he hated his family due to sexual abuse, incest, drugs and alcohol. When asked why he had killed his half-sister he had said "why not".

2.32 On sentencing Q Judge Michael Chambers QC told Q that he had carried out "*a particularly cold, pre-meditated and ruthless killing"* designed to cause *"maximum distress and suffering to her family".* Judge Chambers added *"The murder of your sister was a ruthless and determined act intended to cause her death, clearly with a high degree of pre-meditation,"* In addition Judge Chambers stated, *"You have long-held homicidal thoughts about those who annoy you in general and in particular had long held to kill her, and have shown no remorse whatsoever".* However, what should be noted is that Q's long-held homicidal thoughts only came to light during the investigation of P's death and Q never told any agency that he had any murderous intent towards his half-sister P.

3. ORGANISATIONAL CONTEXT

Stoke-on-Trent Profile

3.1 The unitary authority of the City of Stoke-on-Trent lies within the county of Staffordshire. It became a unitary authority in 1997. P and Q lived at separate addresses within the City of Stoke-on-Trent in an area typified by large areas of privately-owned semi-detached housing.

3.2 According to the English Indices of Deprivation 2015, Stoke-on-Trent is the 3rd most deprived local authority in the West Midlands (out of 33) and the 14th most deprived local authority in England (out of 326).

3.3 The 2011 census recorded the population of Stoke-on-Trent as 249,000, residing in 107,000 households. There were 124,000 males, (49.8%) and 125,000 females, (50.2%).

3.4 86.4% described themselves as White British, 7.4% as Asian or Asian British and 1.5% as Black or Black British.

Local Strategic Context

3.5 The Stoke-on-Trent City Council Strategic Plan 2016-2020 "Stronger Together" sets out the Council's vision 'Working together to create a stronger city we can all be proud of'. Provision of services for high risk victims of domestic violence and abuse contributes to this vision.

3.6 Stoke-on-Trent's Safer City Partnership delivers the national crime, disorder and substance misuse strategies at a local level. The Safer City Partnership Plan 2014-17 identifies violent crime, including domestic abuse as a priority for the City.

3.7 The Stoke-on-Trent Domestic Abuse Partnership has been in place since 2008 and reports directly to the Safer City Partnership's Responsible Authorities Group, the Local Safeguarding Children Board and the Children and Young People's Strategic Partnership Board. Membership consists of statutory sector, third sector and community group representatives.

3.8 Staffordshire Criminal Justice Board Victims and Witnesses sub-group receives performance information concerning, inter alia, domestic violence and abuse, with actions identified and implemented for service improvements. This group, together with the Domestic Abuse Partnership, receives feedback from victims of domestic violence and abuse regarding Criminal Justice Services to inform the identification and implementation of service improvements.

Domestic Violence and Abuse Services in Stoke-on-Trent

3.9 Neither P as the victim nor Q as the perpetrator were referred to domestic violence and abuse services at any time as there was no indication it was required. However, domestic abuse services available in Stoke-on-Trent included:

- Julia House - a purpose built refuge for women and children who have been subject to, or are at risk of, domestic abuse
- A local telephone helpline and an outreach service, including one to one practical and emotional support for women and children (and a small number of men)
- Counselling by trained counsellors
- Personal safety advice and support including the installation of security equipment where appropriate
- An accredited perpetrator programme
- The Freedom Programme - A 12-week course open to any woman who wants to learn more about the realities of domestic abuse. It is designed to empower women, increase their self-confidence and help to improve the quality of their lives.
- Sunrise Centre - The Sunrise Centre is a safe and welcoming service for women, men, young people and children who have survived domestic abuse.

3.10 In addition, had there been any incidents of domestic violence or abuse that reached the threshold for a prosecution then the case could have been heard in the local accredited specialist domestic violence court The specialist domestic violence court programme promotes a combined approach to tackling domestic violence by the Police, the Crown Prosecution Service (CPS), Magistrates, Courts and Probation together with specialist support services for victims as part of a community-wide response to domestic violence. This currently includes three Independent Domestic Violence Advisors (IDVA) who have attended accredited training to provide support for service users and whose goal is the safety of their service users and their children. At the time of writing this report the recruitment process was taking place for two further IDVA posts.

Key Agency Context

City Hospitals Sunderland NHS Foundation Trust

3.11 City Hospitals Sunderland NHS Foundation Trust (CHS) is the leading acute healthcare provider in Sunderland, operating from Sunderland Royal Hospital, Eye Infirmary and the Children's Centre. CHS has policies and procedures in place for safeguarding vulnerable adults and acting on concerns about abuse or neglect which comply with national guidance and the Sunderland's Safeguarding Adults Multi-Agency Procedural Framework. Adult Safeguarding documentation is available to all staff via the CHS intranet site.

3.12 There have been a range of measures and activities within CHS to raise staff awareness of Safeguarding Adults and of suicide and self-harm issues. It is currently mandatory for all clinical staff to undertake safeguarding of adults awareness training (currently updated every 3 years). From 2016 it will be a requirement for all Trust staff (not just clinical staff) to undertake safeguarding adults and domestic violence training.

3.13 Safeguarding Symposiums which include the topics of safeguarding adults and domestic violence are held annually within the Trust. Washington Mind attended in March 2015 and delivered a session on "A Life Worth Living" suicide prevention. Access to this training is available Trust wide.

3.14 CHS also has a "Vulnerable Adults Group" responsible for monitoring and improving the care of vulnerable patients who present to, or who are admitted to CHS. Vulnerable Adults include those subject to Mental Health Act legislation, Adult Safeguarding, substance misuse, challenging behaviour, dementia, learning disability, Deprivation of Liberty, those with impaired capacity etc. The underlying principle of the group is to ensure systems are in place to ensure vulnerable patients' best interests are paramount.

3.15 CHS have five "Domestic & Sexual Violence Champions" that are senior nurses within the Trust. The Trust's intranet has been updated to make information and materials readily accessible to staff and CHS has a named member of staff to provide ongoing advice, guidance and support to Trust staff regarding safeguarding adult issues on a day-to-day basis.

3.16 Q was known to City Hospitals Sunderland following attendances at the Sunderland Royal Hospital Accident and Emergency Department on seven occasions between May 2012 and November 2012. During this period Q was admitted to the Acute Medical Unit on three of these occasions. All attendances were for self-harm incidents usually involving drugs and alcohol.

3.17 It was documented at Q's first visit to the Accident and Emergency Department that he had suffered a recent relationship breakdown however there was never any evidence of domestic violence either past or present being an issue at any of these attendances.

3.18 Q was transferred from City Hospitals Sunderland NHS Foundation Trust to the Cherry Knowle Hospital for inpatient mental health care on two occasions and was returned to the Accident and Emergency Department on two subsequent occasions following further episodes of self-harm. Q stated that these episodes had been under the influence of alcohol and his low mood had been exacerbated due to the recent end of his relationship, loss of his employment and 'problems with the Police'.

3.19 Q absconded from City Hospitals Sunderland on four occasions (two of which were during the same attendance) and Northumbria Police were contacted and attended on three occasions to perform a welfare check and to seek to return Q to hospital for treatment. Q also self-discharged against medical advice from both the Accident and Emergency Department and Acute Medical Unit on four of these occasions. On one occasion, an appointment for the Alcohol Liaison Nurse had been made but Q left before staff were able to give him this appointment. However, Q had been assessed as having capacity before he left and indicated he would see his GP and seek further mental health help.

Gentoo (Sunderland housing provider)

3.20 Q was a tenant of a property owned by Gentoo, a Sunderland housing provider group for a period of fourteen months from November 2011 to January 2013. Gentoo provided services to Q as his landlord. In the first six months of his tenancy there were no issues to address, the rent was paid on time, and there were no problems with anti-social behaviour reported at his address either as the perpetrator or the victim. Q was in a joint tenancy with his then partner and neither identified they had any support requirements on taking up the tenancy.

3.21 In early November 2012 Gentoo were made aware that Q was a patient in Cherry Knowle Hospital due to mental health issues. At this time Q told a Victim Support Officer of alleged issues with a vigilante group who he had been told were outside of his property as a result of him attempting suicide where others could have been placed in danger. There is no evidence in Gentoo's records or in the agency checks made to corroborate Q's claim that he was in danger as a result of vigilante activity.

3.22 Q advised the Victim Support Officer shortly before his discharge from hospital that he could not return to his home for the reasons he had stated before and therefore, would like to terminate the tenancy. He was encouraged to think about this decision and given advice around housing options and finding his own alternative accommodation. At this time multi-agency working was developed with a range of partners but the relationship with CHS was in its early stages. There is no evidence in the records of multi-agency planning with Cherry Knowle Hospital to respond to Q's housing needs at this time.

3.23 There was no evidence of domestic abuse being an issue during the term of this including when Q was living there with his partner. However, had there been any issues or concerns regarding domestic abuse Gentoo have appropriate policies and procedures in place to identify and refer any such concerns.

National Probation Service – North East Division

3.24 National Probation Service North East Division is a legacy organisation that came into being following changes made under the Offender Rehabilitation Act. From 1 June 2014 the responsibilities formerly undertaken by the Northumbria Probation Trust were split between two new organisations:

- the National Probation Service retaining responsibility for high risk offenders
- the Northumbria Community Rehabilitation Company responsible for medium and low risk offenders.

3.25 During the scope of the review the responsible organisation was therefore Northumbria Probation Trust. Their involvement began in August 2008 when Q's supervision on licence was transferred on him moving to Sunderland from Stoke-on-Trent. Q had been sentenced to 54 months' custody by Stoke-on-Trent Crown Court in March 2006 for an offence of Wounding with Intent. Following his release from prison in April 2008, Q's prison licence was initially referred to Staffordshire and Stoke-on-Trent Probation Area. On transfer to the Northumbria Probation Trust, having been identified as a Medium Risk of Serious Harm, Tier 3 offender Q was allocated a qualified Probation Officer as his Offender Manager. This was a requirement of Q's sentencing plan due to the assessed risk and likelihood of reoffending especially in times of high emotional arousal.

3.26 Flags were also placed on Q's electronic record to identify him as being a MAPPA Category 2 offender managed at Level 1[5], and a domestic violence perpetrator (due to a caution for assault against a male partner in 2004). His sentence plan on transfer identified the following objectives:

- To address alcohol misuse and raise awareness of links to offending behaviour
- To address anger and temper issues which link to offending behaviour

3.27 Q made an unplanned move back to Stoke-on-Trent in May 2009 and was transferred to Staffordshire and Stoke-on-Trent Probation Trust for a further brief period of supervision. He then returned to Sunderland in December 2009 following his conviction in Stoke-on-Trent for motoring offences. Q remained supervised by Northumbria Probation Trust and completed his 100 hours of unpaid work without incident in July 2010. A final OASys assessment assessed Q as posing a medium risk of harm to public and known adult, a low risk to children and staff and a medium risk to prisoners when in custody.

National Probation Service – Staffordshire and Stoke

3.28 The National Probation Service Midlands is a legacy organisation that came into being following changes made under the Offender Rehabilitation Act 2014. From 1 June 2014 the responsibilities formerly undertaken by Staffordshire and West Midlands Probation Trust were split between two new organisations:

- the National Probation Service retaining responsibility for high risk offenders
- the Staffordshire and West Midlands Community Rehabilitation Company covering the Stoke-on Trent area through the Reducing Reoffending Partnership is responsible for medium and low risk offenders.

3.29 Both organisations' policies (including those relating to Domestic abuse) were carried across at a local and national level to the two new bodies. In respect of MARAC both organisations engage with the process.

3.30 Staffordshire and West Midlands Probation Trust was itself an amalgamation of two former separate probation areas of Staffordshire and West Midlands. The merged Trust came into being on the 1 April 2010 and Staffordshire and West Midlands became one of the largest probation trusts and employed almost 1000 staff with over 21,000 direct service users. Its head office was in Birmingham with satellite offices in all parts of the region including Stoke-on-Trent.

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[5] **Category 2**: All offenders who have received a custodial sentence of 12 months or more in prison for a sexual or violent offence and whilst they remain under Probation supervision.
Level 1: Ordinary agency management level 1 is where the risks posed by the offender can be managed by the agency responsible for the supervision or case management of the offender. This does not mean that other agencies will not be involved, only that it is not considered necessary to refer the case to a level 2 or 3 MAPPA meeting. Ministry of Justice MAPPA Guidance 2012 version 4

3.31 Therefore, during the earlier scope of the review from March 2006 to April 2010 the responsible organisation was Staffordshire and Stoke-on-Trent Probation Area. Following this from April 2010 until June 2014 the Staffordshire and West Midlands Probation Trust was the responsible organisation. For ease of reference these organisations are collectively referred to as Stoke-on-Trent Probation Service within the body of the report.

3.32 Stoke-on-Trent Probation Service held responsibility for the safe and proper oversight of persons under its supervision in the community. Offenders sentenced to twelve months or longer in prison are placed on licence to the Probation Service when they are serving the second part of their sentence in the community. These responsibilities are discharged by three key processes which are risk assessment, risk management and offender management. The probation area also had responsibilities for liaison with victims of qualifying offences.

3.33 Stoke-on-Trent Probation Service had involvement with Q during three distinct periods. The first period was during his time in custody from March 2006 to April 2008 when Q was allocated a Probation Officer who liaised with prison staff. Stoke-on-Trent Probation Service continued their involvement with Q following his release from prison on licence in April 2008 and until August 2008 when he moved to Sunderland. Q subsequently came back under the supervision of Stoke-on-Trent Probation Service when he made an unplanned move back to Stoke-on-Trent in May 2009. However, by December 2009 he had returned to Sunderland following his conviction for alcohol related motoring offences and he saw out the term of his licence there.

3.34 Stoke-on-Trent Probation Service next had involvement with Q when he was sentenced in June 2013 to a twelve months Community Order with twelve months' supervision for criminal damage offences committed in Sunderland in October 2012. Q was assessed and supervised by his Probation Officer until the end of his Community Order Sentence and Supervision Order in June 2014.

NHS England North (in respect of primary care services)

3.35 NHS England are responsible for commissioning, either directly or in conjunction with local Clinical Commissioning Groups, primary care health services.

3.36 For the period from 1 May 2012 until the fatal incident in June 2015, P was seen regularly by her GP practice for a variety of illnesses and ailments. These attendances were for anxiety and depression; alcohol misuse; musculoskeletal pain and for sick notes. P engaged well with the practice and there was only one occasion during this time when she did not attend an appointment. The GP did not know the reason for her nonattendance. However, P did not always engage with the interventions that arose from the consultations with the GP. She did not always attend for blood tests that had been requested and did not engage with the Healthy Minds Network in February 2013 and Aquarius from April 2013 onwards when referred by the practice. P saw different GPs on occasions, however, she generally returned to see the same GP who started a particular intervention.

3.37 At no time in the medical notes is it recorded that P had disclosed issues with domestic violence or any family relationship problems. As well as her medical needs her non-medical needs were discussed in relation to her accommodation; being evicted from her council house; losing her belongings or personal documents and her concerns relating to her son which are documented in her medical record.

3.38 Q was registered with a GP but it was confirmed through the Domestic Homicide Review process that he had declined consent to access his GP records. However, it is also known from other agency records that there were periods where Q was not registered with a GP.

North Staffs Combined Healthcare NHS Trust

3.39 North Staffordshire Combined Healthcare NHS Trust (NSCHT) provides Mental Health, Substance Misuse and Learning Disability Services to the population of Stoke-on-Trent, Newcastle under Lyme and Staffordshire Moorlands.

3.40 In 2013, Q had limited contact with the Criminal Justice Mental Health Team having been referred by a Probation Officer around reported previous drug use; an unhealthy relationship where there appeared to be some co-dependency around alcohol that sometimes resulted in situational couple violence[6] and previous hospital admissions in Sunderland. Q attended for an interview and reported problems with anger management and long standing family dynamic issues. An offer of support was made in writing and advised he needed to register with a local GP to access some services however Q did not respond so was discharged from the service.

Northumberland Tyne and Wear NHS Foundation Trust

3.41 Northumberland, Tyne and Wear NHS Foundation Trust (NTW) was formed in 2006 and is one of the largest mental health and disability Trusts in England, employing more than 6,000 staff, serving a population of approximately 1.4 million, providing services across an area totalling 2,200 square miles.

3.42 They work from over 60 sites across Northumberland, Newcastle, North Tyneside, Gateshead, South Tyneside, Sunderland and North Easington and have a number of regional and national specialist services**.** Services include:

- Inpatient Care Group,
- Community Services Group, and
- Specialist Services.

3.43 NTW contribute to the MARAC process in six local authority areas that the trust geographically works within. NTW staff are trained and familiar with using the DASH risk assessment tools that are used routinely across the country. NTW have a Domestic Abuse Policy that was last updated in 2013 and outlines the course of action if employees have concerns regarding domestic abuse and actions required to be taken.

3.44 NTW has a Safeguarding and Public Protection Team that includes specific full-time dedicated Safeguarding Children and Domestic Abuse Practitioners who provide advice, support and supervision for staff when necessary. DASH risk assessments are completed by staff across the organisation and are quality checked by the Safeguarding Children and Domestic Abuse Practitioners to ensure the information is robust and a decision made re next steps. If a MARAC referral is identified these are also checked prior to submission to the Police MARAC Coordinator.

3.45 NTW was involved with Q from May 2012 to late November 2012. Q was not in a relationship at the time of NTW involvement and made no reference to domestic abuse within the familial relationships.

3.46 Q was first referred to NTW Self Harm Liaison Team (SHLT) by City Hospital Sunderland Ward in May 2012 following an overdose, however, he self-discharged after being assessed. The Police were contacted and he was located at home and the Doctor on AMU spoke to Q by phone, informed him of the potential consequences of the medication overdose and

[6] The use of physical force without a context of control. People who engage in situational couple violence tend to be poor communicators who don't know how to fight without resorting to verbal aggression and name calling or physical abuse such as hitting, shoving or damaging property. http://www.project-safe.org/domestic-violence/

strongly recommended he return but he declined. As Q had capacity he was discharged from the service and a letter regarding his recent overdose was faxed to his last GP Surgery in Stoke-on-Trent as Q was not registered with a GP locally.

3.47 Q was next seen in October 2012 after being seen at Sunderland Accident & Emergency department by the NTW Crisis Team for assessment of thoughts of wanting to hang himself. Due to Q's expression of ongoing suicidal ideation and refusal to engage with Home Based treatment an informal admission to NTW West Willows Ward at Cherry Knowle Hospital was agreed with Q. He was discharged two days later for Home Based Treatment.

3.48 The RMN was due to visit Q the following day however Q had been taken to Accident and Emergency after a disclosure of attempting to hang and gas himself. Q then left the department as he was not willing to stay or be seen. However, Q was then returned to the Accident and Emergency Department after being found by Police on a ledge in a multi-storey car park with razor blades expressing suicidal intent and was appropriately assessed by the Section 136 suite at Cherry Knowle Hospital and readmitted.

3.49 On 5th November, there was an incident when Q becomes verbally abusive and he smashed a cup of coffee over the ward desk and left the hospital. This was reported to the Police by ward staff as they felt he was being threatening. Q would not firmly deny whether he would end his life if discharged and he was detained under Section 5(2) of the Mental Health Act. Q then forced a window open and although the grounds were searched he was not found.

3.50 Q then arrived at a friend's house reportedly covered in mud and soaking wet. It was reported that the reason behind Q becoming emotionally upset was because of the removal of his dog. The friend called the Police concerned for his safety. Q was returned to the ward early on 6th November 2012 via the Police.

3.51 Over the following days Q had two psychology sessions in which he advised that both parents were alcoholics and there was a lot of domestic violence. Q spent time in foster care and respite care from the age of about five and social services were frequently involved with his family. Q agreed to start work on anger management sessions the following week.

3.52 During ward round on 9th November Q had made some progress and was reported to understand staff better with no suicidal ideation and no thoughts of self-harm or harm to others. The next day it was recorded that Q interacted with staff and fellow patients throughout the day and no problems were expressed. However, two days later Q went for a walk but then contacted a fellow patient and staff also received a concerned call from Q's brother. The Police were contacted due to the concerns raised.

3.53 Further information was received that Q may still be in the hospital grounds and a Police officer attended and located Q at the bottom of the drive leading into the hospital and escorted him back into the building. Q was then transferred to Sunderland Royal Hospital in the care of a staff member from Cherry Knowle Hospital. However, Q then absconded and the nurse reported to the Police that Q had left the hospital. Officers attended and he was located nearby and returned to Sunderland Royal Hospital. Officers remained with Q until he was assessed and detained under Section 2 of Mental Health Act for assessment.

3.54 Q was treated at the Sunderland Royal Hospital for the paracetamol overdose that he had taken while on grounds leave and was returned to Cherry Knowle Hospital in the early hours of 13th November 2012 having been declared medically fit for transfer. Q continued with his anger management and emotional regulation work during his psychology session. Q was reviewed by the Consultant Psychiatrist on 19th November 2012 and his diagnosis was confirmed as Emotionally Unstable Personality Disorder. Q had no thoughts of self-harm nor thoughts of hurting anyone, Q was, therefore, informed that his section would be rescinded

and he was given the option of staying in hospital for treatment as a voluntary patient. Q informed staff he would stay in hospital as he didn't have a home.

3.55 However, the next day Q was observed to be verbally hostile and abusive towards a fellow patient and was told that this behaviour would not be tolerated. The following four days passed without incident. Q had a further psychology session and was reported to be working on negative automatic thoughts and using a thought diary to good effect. Q remained very polite on the ward, helpful towards others and no problems were noted.

3.56 However, the following day Q had an altercation with a staff member. Q was assessed by the psychiatrist on call as exhibiting no evidence of depression and denying any suicidal or homicidal thoughts or plans. Q was therefore not detainable under the Mental Health Act. Q decided to leave and signed a discharge form. Q was offered follow up with the Crisis Team but he refused this and was advised to avoid alcohol and drugs as these put him at increased risk. A discharge summary was sent to his GP from the consultant psychiatrist.

3.57 Several attempts were made by a Community Psychiatric Nurse (CPN) to contact Q by telephone to arrange his seven day follow up assessment without success. The CPN also contacted Q's brother as well as his GP practice before closing his case.

3.58 In August 2013, the Criminal Justice Mental Health Team (CJMHT) in Stoke-on-Trent contacted Northumberland Tyne and Wear NHS Trust following their assessment of Q and after reading his interim discharge documentation from the ward on Cherry Knowle Hospital. This discharge summary identified Q as a '1' on a risk assessment for "risk to a child" and the CJMHT had concerns that Q was living with a child in the same property. These concerns were referred to Vulnerable Children and Corporate Parenting in Stoke-on-Trent and as a result, children were not allowed in the property while Q was present.

3.59 Northumberland, Tyne and Wear NHS Foundation Trust had no involvement with P.

North East Ambulance Service

3.60 The North-East Ambulance Service provides a number of NHS services, and covers the counties of County Durham, Northumberland, and Tyne and Wear, along with the boroughs of Darlington, Hartlepool, Middlesbrough, Redcar and Cleveland and Stockton-On-Tees.

3.61 North East Ambulance Service staff provided services to Q on seven occasions from early May 2012 to early November 2012. Five of these attendances were as a result of calls by Q to the emergency services via 999 and on one occasion via a call to NHS Direct on 111. Each of these attendances was in relation to self-harm by Q who had taken an overdose of medication and each also involved an element of alcohol misuse. On one occasion, the attendance by ambulance staff was as a result of an urgent transport request for Q from Sunderland Royal Hospital.

3.62 During each of these attendances Q was appropriately clinically assessed, observed by ambulance staff and transported to Accident and Emergency Department and on one occasion from there to Cherry Knowle Hospital. Handover documentation was appropriately completed on each occasion. Q did not give any indication at any time to call handlers or ambulance staff that he may pose a threat to any of his family members.

3.63 North East Ambulance Service staff had no contact with P.

Northumbria Police

3.64 Northumbria Police serves a population of 1.5 million people and covers an area of more than 2,000 square miles in the North East of England, from the Scottish border down to County Durham and from the Pennines across to the North-East coast.

3.65 Northumbria Police had no contact with P or any members of her family apart from Q. Between 2004 and 2012, Q had contact with Northumbria Police on four occasions, mainly with regards to domestic violence.

3.66 In April 2012, a fourteen-year-old boy alleged that he had engaged in sexual acts with Q in return for money and cannabis. Q was arrested and on interview he denied any knowledge of the alleged offence. Due to variations in the boy's account and a lack of corroborating evidence a decision was taken by the Crown Prosecution Service in May 2012 to take no further action regarding the allegations.

3.67 Between early May 2012 and end of June 2012 Northumbria Police responded to four calls either from the Ambulance Service, a relative or a friend requesting assistance due to concerns that Q had taken an overdose, self-harmed or was feeling suicidal.

3.68 In July 2012, a neighbour of Q reported that after she had confronted Q regarding her purse being missing he had assaulted her with a hammer on her shoulder. Q was arrested on suspicion of assault and subsequently placed on Police bail for further investigation. However, there was no physical evidence of assault and the complainant retracted her allegation. Q was, therefore, released with no further action.

3.69 Officers again attended to concerns regarding self-harm at the end of September 2012 and again the end of October 2012 officers. On the first occasion Q was found to be fit and well and on the second occasion he was taken to Sunderland Royal Hospital and admitted.

3.70 In October 2012 following a report from a friend of Q that his vehicle tyres had been slashed Q attended the Police station and admitted the offence. He also admitted he may have damaged other vehicle tyres in the same street. Q was subsequently charged and was convicted in June 2013 of three counts of criminal damage and received a twelve-month supervision order.

3.71 In early November 2012 Northumbria Police received a call from the Ambulance Service reporting the Q was threatening self-harm. It was established by the Fire Service that damage had been caused to the gas boiler. Q was taken to Sunderland Royal Hospital to be assessed. When officers checked with the hospital they were informed that Q had been seen and discharged an hour before. Northumbria Police then received a call from a member of the public that a male was sitting on a ledge on the top floor of a multi-storey car park in the centre of Sunderland. On attendance, this male was identified as Q.

3.72 Due to the circumstances and location this was declared a critical incident and was managed by a Superintendent. 24/7 response officers, who had been made aware of the incident earlier that day engaged with Q and offered to transport him straight to hospital if he wished. After approximately 30 minutes Q agreed to go with officers to hospital and he was detained under the Mental Health Act. As there were no offences there was no further Police action required.

3.73 Northumbria Police's next involvement with Q was five days later as a Missing Person when he was an inpatient at Cherry Knowle Hospital. When officers attended it was established that Q had asked to be discharged however on assessment the decision was taken to detain him under Section 5(2) of the Mental Health Act. Q was not happy with this and he forced a window in his room.

3.74 The grounds were searched and Q was not found and a call was received from a female friend who lived approximately 10 – 15 minutes' walk from the hospital reporting that Q had turned up there. Officers attended and escorted back to the hospital as a place of safety no further Police action required.

3.75 Two days later Q called Northumbria Police from Cherry Knowle Hospital reporting that he had received threats to kill him from his neighbours and an unknown person had been asking neighbours for his bank card as he owed money. Officers attended and spoke to Q in the presence of a nurse. He stated that he had received third hand information that his neighbours were not happy with him being resident at his home due to the tyre slashing incident and the self-harm attempt when he damaged the gas boiler. When officers attempted to give him advice he became abusive and left the room. No safeguarding issues or offences were identified and no further Police action was taken.

3.76 Three days later a call was received from Cherry Knowle Hospital reporting Q missing. He had left the ward threatening self-harm, and he may have taken some tablets and be in the possession of alcohol. An officer attended and searched locations where Q may have gone and finally located Q at the bottom of the drive leading into the hospital and escorted him back into the building. As he claimed to have taken a quantity of tablets, Q was escorted to Sunderland Royal Hospital in company with a staff member of Cherry Knowle Hospital and left in their care.

3.77 Shortly after a report was received from Sunderland Royal Hospital that Q had absconded. On attendance Q had returned however a further call was received reporting that Q had left the hospital once again. Officers attended the location where Q had last been seen and commenced an area search. He was located nearby and returned to Sunderland Royal Hospital. In order to prevent any further incidents officers remained with the nurse and Q until he was assessed and detained under the Mental Health Act.

Staffordshire Police

3.78 Staffordshire Police provide policing services for Staffordshire and Stoke-on-Trent.

3.79 Between May 2012 and June 2015 P contacted Staffordshire Police on six occasions. Once in relation to concerns regarding feeling threatened by people outside her property, three times regarding damage to her property, and finally in June 2015 to retrieve her personal possessions from her ex-partner's address. P had no recorded convictions.

3.80 Staffordshire Police had contact with Q as an offender, as a victim and also as a person in need of assistance to safeguard their welfare.

3.81 In February 2013 Northumbria Police contacted Staffordshire Police asking them to arrest Q for failing to respond to his bail following the criminal damage incident in Sunderland in October 2012. Q had in the intervening period been an inpatient at a Cherry Knowle Hospital and on his discharge failed to present himself to Northumbria Police. Q moved out of his last known home address in Sunderland and enquiries by Northumbria Police led them to believe he was residing at an address in Stoke-on-Trent. Following enquiries Q was arrested by Staffordshire Police in Stoke-on-Trent in March 2013 and was charged with the criminal damage offences on behalf of Northumbria Police.

3.82 In early May 2013, Q was arrested for a racially aggravated assault on his neighbour and further enquiries revealed he was wanted on warrant from Sunderland Magistrates Court for failing to appear over alleged offences of criminal damage. Although the assault complaint was withdrawn Q was arrested regarding the breach of his bail conditions in relation to the criminal damage in mid May 2013.

3.83 A brother-in-law to Q reported to the Police in December 2013 that Q was arguing with his teenage son, Q's nephew, at their home address. Officers attended and the nephew refused to make a statement and he and his parents did not wish to support a complaint or prosecution.

3.84 In August 2014, a member of the public contacted the Police to report two males had vandalised a number of cars parked along a residential street in the early hours of the morning. Q and one of his older nephews were arrested on suspicion of having caused the damage.

3.85 A dispute was reported at P's daughter address in September 2014 between Q and his nephew. Police attended and it transpired that during an argument they had begun to push each other and the nephew had sustained a minor cut to his lip.

3.86 All front line Police officers in Staffordshire undertake mandatory training on recognising and responding to domestic violence and abuse and to mental health issues. Mental health professionals are available to attend incidents with Police officers and in custody suites to provide mental health advice. Staffordshire Police's response to any issues of vulnerability is included in the analysis section of the report.

Stoke-on-Trent City Council Vulnerable Children and Corporate Parenting

3.87 Stoke-on-Trent City Council's Vulnerable Children and Corporate Parenting Services provide statutory children's social care services in Stoke-on-Trent.

3.88 CJMHT referred concerns to Vulnerable Children and Corporate Parenting in August 2013 that Q was a possible risk to children due to anger management and mental health issues and that although a sexual assault charge dismissed, mental health staff at Northumberland Tyne and Wear NHS Foundation Trust had classed Q as a risk to children. Their involvement was, therefore, not in relation to Q but with the children of his relatives who were having contact while Q was present in the property.

3.89 The Social Worker visited the home and informed Q that he needed to find alternative accommodation and confirmed her concerns and expectations in writing both to family members and Q.

Stoke-on-Trent City Council – Co-operative Working (Housing Services)

3.90 Council housing within Stoke-on-Trent is managed and maintained by the City Council. They own and provide a range of landlord services to 19,100 properties and 340 leaseholders. The service operates from a number of offices across the city and provide housing services to tenants living in council estates in some areas of the city. The team is currently expanding to cover troubled families across all tenures, under the Co-operative Working banner whilst this is still in development it is not fully operational at the current time and was not in place during the scope of the review.

3.91 P held a tenancy with Stoke-on-Trent City Council from April 1994 until her eviction in December 2013 due to substantial rent arrears. During the scope of the review there were a number of complaints concerning anti-social behaviour, noisy parties and smashing of windows. P's life style was, therefore, somewhat chaotic but possibly due to her associates, people were fearful of reprisals if they reported anything. As a result, very few complaints were ever progressed as there was no substantiating Police evidence. Eventually she was

deemed to be intentionally homeless and non-priority, and referred to the Salvation Army and Arch [7].

3.92 Q commenced his tenancy with Stoke-on-Trent City Council in February 2014 and identified that he had some mental health needs but was not vulnerable. During two tenancy review visits over the next six months no issues were identified.

Substance Misuse Services

3.93 The involvement of the substance misuse services with Q was limited to a single episode in October 2009 to March 2010 when Q self-referred to ADSIS (the then provider of the Stoke-on-Trent Community Alcohol Service) to seek support and treatment of his alcohol dependence. The service completed a full comprehensive assessment of care and inpatient detoxification requirements following which Q was referred for inpatient detoxification from alcohol. However, Q failed to present for admission or make contact with the service following their assessment and they closed his case. This was in line with their policy for voluntary referrals and admissions to services.

3.94 In April 2013 P was assessed by a therapist at Healthy Minds Network as not being suitable for Cognitive Behavioural Therapy due to the amount of alcohol she was consuming. The therapist referred P to Aquarius for support to manage her alcohol consumption. P stated in June 2013 that she had not heard from Aquarius and she did not contact them despite numerous requests and advice from different GPs for her to do so.

4. ANALYSIS

Offender management

4.1 The analysis by National Probation Service covers a longer period than other contributors as it commences with Q's period of imprisonment from 2006 to 2008 and his release on licence. The analysis also covers the period of supervision undertaken on the Community Order after Q had returned to Stoke-on-Trent in 2013.

4.2 In terms of the custodial sentence it is apparent from the records that Q was moved prison on several occasions due to "ghosting"[8] Although Q's Sentence Plan OASys included the need to undertake work on anger management, this was never undertaken whilst in custody.

4.3 There are a number of occasions when Q demonstrated impulsivity. Firstly, when he left his employment with Sainsbury's in May 2008. This is further evidenced in his moves between Stoke-on-Trent and Sunderland. He received a visit from his ex-partner and within one week he had moved up to Sunderland. The transfer between probation areas correctly followed the procedures appertaining to a medium risk of harm case at the time. It is noted however, that Q, under the conditions of his licence, was supposed to seek his Offender Manager's prior permission to reside other where than his home address for even one night. In this instance, it appears that a pragmatic approach was taken and the transfer was proceeded with rather than enforcement action being taken following Q's initially unsanctioned move to Sunderland.

[7] Arch is a registered charity that works with people who are in housing need or crisis, including but not solely victims and perpetrators of domestic violence and abuse. Services are provided for children, young people, adults and families in local communities across Stoke-on-Trent.

[8] a term used to describe the movement of prisoners around the prison estate when there are difficulties with managing the individual but there is no evidence that can be used in an adjudication

4.4 Whilst residing in Sunderland between August 2008 to May 2009 and December 2009 to July 2010 Q was supervised by an Offender Manager as a tier 3 Medium Risk of Serious Harm Offender. The legacy provider of Probation services in Sunderland at the time of receiving Q's on a transfer from Stoke-on-Trent Probation was Northumbria Probation Service. Q's prison licence was transferred to the Sunderland Pennywell and Southwick Offender Management Team in August 2008. His Offender Manager retained management of Q on his licence until he moved back to Stoke-on-Trent in May 2009. They then resumed management of the case in December 2009 following Q return to Sunderland and retained management until the licence and sentence expiry in July 2010. As such this case was correctly allocated.

4.5 As per transfer procedures between Probation service providers, a full OASys (Offender Assessment System) was completed by the Offender Manager prior to transfer. The sentence plan linked to this OASys assessment identified Q as being very motivated to address his offending.

4.6 Immediately upon receipt of Q's case in Sunderland in August 2008 a discussion was held with Northumbria Police and it was appropriately agreed that Q would be managed as a MAPPA Category 2 Offender. This is highlighted as good practice and necessary to managing the case correctly.

4.7 Q was offered appointments at intervals appropriate to his assessed level of risk throughout the time he was supervised in Sunderland. Areas identified as having being linked to his risk of harm and likelihood of re-offending (identified in OASys and in his sentence plan) were regularly discussed in supervision sessions with Q showing a willingness to discuss things such as alcohol use, employment, relationships and use of leisure time in an open and apparently honest manner.

4.8 Whilst there is no specific mention of P in the case records with regards to the potential for domestic abuse, this is not unexpected as Q was living in a different city to her at that time and there had been no indicators or potential for her being a victim at his hands throughout the time Q was supervised in Sunderland. Q was visited at his home address on two occasions and his then partner was present during one of these visits in November 2008. This is an example of good practice to establish any underlying issues at the home address including potential domestic abuse, no such signs were evident at these visits.

4.9 Q's relationship with his family in Stoke-on-Trent was discussed in supervision sessions during this time period with Q commenting upon limited contact during visits to Stoke. This showed an awareness of how there were risk factors associated with contact with his family. On November 2008 Q stated he had not visited an unnamed sister as planned because '*there is always a drama*' and he had had enough of it. However, the Offender Manager did not appear to have taken an investigative approach to discovering what Q was referring to in this comment. It could be argued that if such an approach had been adopted perhaps a richer picture of the relationship Q had with his family at this time may have been provided and used to inform OASys risk assessments as well as areas of support and any negative influence in the community.

4.10 In May 2009 Q made contact with the Sunderland Office to advise he had moved back to Stoke-on-Trent along with his partner. When speaking with his Offender Manager Q advised that the move was due to a family emergency but would not disclose what this was. The Offender Manager identified this failure to disclose as a less than positive sign and correctly advised Q that by residing for even one night at an address not prior approved by his Offender Manager, he had in effect breached his prison licence.

4.11 It is the view of the IMR Author for Northumbria Probation that given the excellent compliance demonstrated by Q to this point, and that he had provided an address (which

although not known at the time turned out to be that of P) the Offender Manager took a pragmatic view and arranged for this address to be assessed by colleagues in Stoke-on-Trent with view to a transfer rather than issuing a warning on Q's licence or seeking his recall to custody. There is evidence of communication and sharing of risk of harm with colleagues in Stoke-on-Trent in the contact log. The transfer to Stoke-on-Trent Probation and a return to the case management of his first Offender Manager was finalised four weeks later.

4.12 The IMR author for Northumbria Probation noted there was no evidence of the Offender Manager having completed a review assessment of OASys or Q's sentence plan during the time period 19th August 2008 to 11th June 2009. In line with the National Standards for the Supervision of Offenders issued in 2007 (since superseded) an OASys assessment and sentence plan review should have been completed following Q's arrival in Sunderland and reviewed every sixteen weeks thereafter. There was also no evidence of a review being completed prior to the case being transferred as would be expected to reflect the change in circumstances and reassess criminogenic needs and risk. This appears to be an individual failing on behalf of the Offender Manager, while the role of supervision in ensuring compliance is also noted to be key to this.

4.13 Therefore, in June 2009, less than a year after he left Q was back in Stoke-on-Trent and an OASys assessment was completed by his Offender Manager which was appropriately reviewed by the Senior Probation Officer. However, in November 2009, Q was the subject of a new Community Order with 100 hours of unpaid work which was imposed by Stoke-on-Trent Magistrates for offences of Driving with Excess Alcohol and Failing to Report an Accident. Q then decided to return to Sunderland fewer than six months after arriving in Stoke-on-Trent. A further OASys assessment was therefore, completed by Stoke-on-Trent Probation prior to making a transfer request to Northumbria Probation in early December 2009.

4.14 The Offender Manager making the transfer from Staffordshire had reviewed OASys and also completed a Spousal Abuse Risk Assessment (SARA) prior to the transfer formally being completed. This is highlighted as good practice as these assessments highlight how a period of instability in relationships, lack of employment and excessive alcohol use were risk factors associated with both risk of harm and likelihood of re-offending. In the OASys document completed in December 2009 Q was assessed as posing a medium risk of harm to public and known adults whilst in the community, a low risk of harm to children and staff in the community and a medium risk of harm to prisoners in a custodial environment. The SARA assessment, primarily used to assess risk to partners and completed the same day identified Q as posing a medium risk of violence towards a partner and a medium risk of harm towards others.

4.15 Q had returned to Sunderland and resumed his relationship with his ex-partner. The OASys assessment completed in Stoke-on-Trent in December 2009 comments upon Q having split from a new partner in Stoke-on-Trent and wanting to return to Sunderland. There is also comment in this OASys document about how Q considered this new partner's alcohol use was the main problem in this relationship and this coincided with Q's own return to excessive alcohol use. Whilst under the supervision of the Offender Manager in Sunderland, there is evidence of Q acknowledging the risks associated with excessive alcohol use and his self-reported efforts to avoid excessive alcohol consumption.

4.16 Q missed an appointment with a duty officer on 31st December 2009 and was issued with a first warning on licence enforcement letter on the same day. This is an example of timely and appropriate enforcement action. The warning was withdrawn on 5th January 2010 when Q attended his next appointment and a self-certified sickness absence was accepted with Q citing a vomiting bug for his non-compliance.

4.17 There is evidence of a management review by a Senior Probation Officer in mid-January 2010 in which it was decided that given the stability, good reporting and no immediate risk identified except that towards his partner at that stage, the case could be transferred to a reporting centre scheme with the Offender Manager retaining oversight and risk management of the case whilst the supervision appointments would be undertaken by a Probation Service Officer. Any increase or new identified risk would result in the case returning to the direct management of the OM. This appears to have been a defensible decision at the time given the presentation of Q. As a result of this decision Q would be seen every four weeks by his Offender Manager and every three weeks on the reporting scheme. During the remainder of his time under supervision on his licence, Q engaged very well, was proactive in seeking employment and there were no further concerns regarding an increase in risk.

4.18 At the end of March 2010 at short notice Q advised he would be travelling to Stoke-on-Trent to visit family and provided an address. He was advised that his relative would need to confirm these arrangements before he would be given permission to travel. On 1st April 2010 Q was reminded of the need to provide advance notice of potential overnight stays for a risk assessment to be carried out. He stated he did not go in the end but recognised the need to provide more notice. Also at this appointment he commented upon how a call centre training course was going well, how his relationship with his partner was good and how his alcohol use was under control. The Offender Manager completed a review of Q's OASys document including a full risk assessment and review of his sentence plan on 9th April 2010. The objectives in Q's sentence plan were unchanged and marked as ongoing. The risk assessment identified him as posing "*a medium risk of harm to public and known adult (those with a close relationship to him i.e. partner or family member), a low risk to children and staff and a medium risk to prisoners when in custody*".

4.19 Q completed his 100 hours of unpaid work without incident on 7th April 2010. On 18th June 2010 during a planned appointment Q disclosed he had lost his job at a call centre due to not hitting sales targets but was positive in his outlook regarding finding new employment. He also disclosed he had started to write a book and was looking to enrol on a creative writing course.

4.20 Q's final appointment on licence occurred on 1st July 2010 and his progress on licence was discussed. The Offender Manager commented '*'Q has a tendency to be a little over optimistic about progress made given that there has been further offending during licence and I am of the view alcohol misuse can sometimes be problematic. Q acknowledges that he has a tendency to get involved in other people's problems to try and help them resolve things but this can lead to greater problems. This was the circumstances of the index offence and he needs to be wary about this. However, this is not to say that some progress has not been made as he does appear settled in [his] relationship and has purposefully distanced himself from negative family relationships." Q's* Licence expired on 4th July 2010.

4.21 Q moved transiently between Probation areas during his time on licence which may have frustrated the management of the custodial and community sentences, however there is no evidence to suggest that the transfers between areas were not managed effectively. Probation Instructions regarding the allocation and transfer of cases were revised and reissued in 2014.

4.22 The final OASys assessment (at termination of licence) did reflect that Q had been a very compliant offender during the time he was managed in Sunderland and there was evidence of a slight reduction in the level of risk of harm posed by Q recorded in this document. However, with hindsight, a more investigative approach on behalf of the Offender Manager may have yielded a richer source of information, particularly in respect of Q's relationship dynamic with partners and family members to assist in the assessment of protective factors and risk factors linked to further offending and the risk of serious harm to others.

4.23 Guidelines regarding the frequency of OASys reviews have changed since this time and it is now expected that OASys will be reviewed in response to a change in circumstances. OM2 did not reassess the offender's needs and risks in line with national standard timescales at the time, or in response to the change in circumstances. This is an individual failing rather than an organisational learning point and this Offender Manager is not now employed as a Probation Officer in Northumbria.

4.24 Further to the changes introduced through Transforming Rehabilitation[9], all the policy and guidance in existence at the time of Northumbria Probation's involvement in the management of the offender has been updated.

4.25 Q then did not come to the attention of the Criminal Justice agencies in Stoke-on-Trent until 2013 when his case was again transferred into Stoke-on-Trent following further offending. It would appear his longstanding relationship had broken down and he had become involved in a more casual relationship. When this ended he took revenge on his most recent ex partner's car.

4.26 Q was informed that his likelihood of council re-housing was bleak and his reaction was to state he would move back to Sunderland again. However, he remained in Stoke-on-Trent following the guidance of his supervising officer. Q resided with his ex-brother-in-law and due to his nephew's contact arrangements with his father taking place in the property child protection concerns were raised. Q's anger management concerns became more apparent in this period as he had to deal with professionals knowing more about his mental health issues and also about a sexual abuse allegation in Sunderland where no further action is recorded. As a consequence, his case is correctly transferred back to a qualified member of staff. Q had also previously expressed dissatisfaction with having an unqualified worker allocated to him. His emotional responses emerged negatively on one further occasion when he was disappointed by the outcome from a meeting with the housing department as referenced above.

4.27 Although the sexual abuse allegation was closed, Probation rightly explored this with Q and clarified their ongoing concerns in respect of anger management and mental health issues with children's services in respect of Q's nephew. An agreement was signed with children's social care services by both of the nephew's parents that Q would not share a bedroom with the child concerned and that he needed to leave the property during contact so that the child could have access to his father unimpeded. Some flexibility was shown towards Q's housing needs so that he was not homeless over the Christmas and New Year period 2013-2014.

4.28 During 2013, whilst supervised in Stoke-on-Trent, Q's Probation Officer worked with him on his own history of parenting as a child, victim issues, anger management and very practical support of getting him appropriately re-housed. The period of supervision ended relatively positively during which Q talked about his sister returning from a trip abroad and being with a partner he did not like. Q had mentioned fighting within the family as being problematical but denied there were any issues for him. Q had always described family as being very important to him.

4.29 Throughout Q's supervision in Stoke-on-Trent his risk was actively managed with regular OASys assessments. The risk assessments were regularly updated to reflect risk to staff and risk to children and then amended when more information came to light to change the assessment.

4.30 The Domestic Violence flag was, however, not put on the case until October 2015 and this should have been an active flag from 2008. Furthermore, the MAPPA flag was not entered

[9] Transforming Rehabilitation is the name given to the government's programme for how offenders are managed in England and Wales from February 2015. Transforming Rehabilitation: A Strategy for Reform (May 2013), Ministry of Justice

until September 2013 and again this should have been entered on the case in 2008. However, whilst the MAPPA 'flag' would now be regarded to be crucial to the management of the case the seriousness of the omission of the 'flag' would have been seen differently in 2008. Is should be noted however, that the lack of the 'flag' did not have any bearing on the interventions provided or Q's later decision to murder P.

4.31 The reorganisation of prisons into resettlement and non-resettlement should ideally preclude as many prisoners from being "*ghosted*" around the prison estate but nevertheless there will always be issues in respect of rationing interventions whilst someone is incarcerated. As Q was assessed as medium risk of serious harm he would not have been seen as a high priority for programme interventions and this situation has not changed.

4.32 Legislation has been tightened in terms of how easily offenders can move around the country. Previously it was only offenders who were assessed as high risk of serious harm who were subject to restrictions. As Q was always assessed as medium risk of serious harm he therefore experienced a degree of latitude in this respect. This would no longer be an issue as all offenders, irrespective of risk of harm levels, now have to seek approval before moving address as under the Offender Rehabilitation Act 2015.

4.33 The sexual abuse allegation in Sunderland was taken seriously by all agencies and information was shared confirming there was to be no further action in the matter. There continued to be evidence of good liaison between Probation and children's services and Probation's ongoing concerns re Q's anger management and mental health issues were taken seriously by children's social care.

4.34 Some of the early flagging of relevant risk registers i.e. Domestic Violence and MAPPA in the case recording system was not accurate. Q should have been flagged as a MAPPA Category 2 case until the end of his licence period. However, NPS now has monthly data quality assurance checks which minimises human error. This is because the electronic OASys assessment system does not automatically generate all the relevant flags in the case recording system and relies on human data input.

Mental health of the perpetrator and effectiveness of services

4.35 It was known that Q had mental health needs at various times throughout his life and his first known voluntary admission to a mental health ward was in 2001. The first relevant period during the scope of the review was when Q was referred into the Criminal Justice Mental Health Team in 2009. However, this could not be followed through as Q was not signed up with a GP which was a prerequisite of being accepted in to this service and his case was therefore closed.

4.36 In May 2012 Sunderland Royal Hospital referred Q for a Self-Harm Liaison Service assessment after having presented at the Accident and Emergency Department indicating he had taken an overdose of medication and alcohol. He was offered two assessments by the Self Harm team nurse however he declined on both occasions, he left the Accident and Emergency Department without a medical review. He was contacted by telephone by the Accident and Emergency Doctor regarding the risks of not being medically assessed, refused to return and a welfare check was undertaken by the Police following them receiving a call from the Ambulance Service requesting assistance at his home address. They informed Police that Q had called them reporting that he had taken an overdose and needed assistance to gain entry. Officers attended and gained entry to the property.

4.37 It was established that Q had taken paracetamol therefore officers accompanied him to Sunderland Royal Hospital and left him in the care of staff. A call was made to the hospital and officers were updated that he had been admitted to a ward and was stable, although he

was refusing to see the Crisis Team. A call was later received by the Police from the hospital reporting that Q had absconded.

4.38 Officers attended his home address and located him fit and well; however, he refused to return to the hospital. When the hospital was updated they stated that he had to be returned as he had taken tablets. Hospital staff were informed that as Q had been coherent and capable of making a rational decision Police had no powers to force him to return. No further action was taken. The Self Harm Team Nurse wrote to Q's last registered GP who was in Stoke-on-Trent of the presentation and unwillingness to have any assessment or treatment.

4.39 On 10th June 2012 a call was received by Northumbria Police from a friend of Q reporting that he had received a text threatening self-harm. The friend stated that Q was not at home and would call him to attempt to locate him. A further report was received from this male stating that Q was on route to his address and described the route he would take. Officers attended the area and located Q. It was established that he had no intention of self-harm; this was a cry for help over financial issues. Q was left in the care of his friend. No Adult Concern Notification (ACN) was raised with the rationale given that the initial threat was not a real threat to self-harm.

4.40 The next day a call was received from the Ambulance Service requesting assistance at Q's home address. They reported that Q had called stating he had taken a quantity of tablets and had cut himself with a knife. On attendance he had a small cut to his left eye and disclosed that he had taken a quantity of tablets. Officers therefore accompanied him to Sunderland Royal Hospital and after being assessed he was taken home by officers. As per policy, no ACN was raised as hospital staff have a responsibility to share information with Adult Services.

4.41 On 21st June 2012 a call was received from the Ambulance Service requesting assistance at Q's home address. They reported that Q had called them stating he had taken an overdose and was threatening to cut himself. 20 minutes later a call was received from a friend of his reporting that he had received a text threatening self-harm. On attendance it was established that Q had taken a quantity of tablets prescribed for depression and had not harmed himself with a knife. He was co-operative with paramedics and was left in their care to transport to Sunderland Royal Hospital. No further Police action was taken. In accordance with the policy no ACN was raised to prevent duplication.

4.42 On 30th September 2012 a call was received from a friend of Q reporting that he had received a text from Q threatening self-harm with a dog lead. Officers attended his home address where they found him asleep in bed. Q was fit and well and informed officers he had sent the text a number of hours earlier when he was "*hacked off*". No ACN was raised although given the previous incidents it would have been appropriate to do so.

4.43 In October and November 2012 Q was seen at Sunderland Accident and Emergency Department by the NTW Crisis Team (of two RMN's) for the purpose of assessment as he was having thoughts of wanting to hang himself.

4.44 On 29th October a request was received from the Ambulance Service reporting that Q had been smoking cannabis and was threatening self-harm. Q was known to Ambulance Service as being violent and aggressive. On attendance Q was calm and co-operative. He was taken to Sunderland Royal Hospital by officers and later admitted to Cherry Knowle Hospital. No further Police action was required. No ACN was raised as per the policy to prevent duplication.

4.45 The same day a report was received from a friend of Q that his vehicle tyres had been slashed. On 31st October Q attended the Police station and admitted the offence. He also admitted he may have damaged other vehicle tyres in the same street. During interview he

was described as argumentative and agitated; however, he would not discuss any issues that may be affecting his demeanour. He admitted that he had been stealing money from his friend by using the victim's card to obtain cashback when he was shopping for him. No crime report was raised for this as no complaint was made as the injured party did not believe any offence had been committed. Q also stated that when the victim told him about the tyres he remembered that he was responsible. Q was subsequently charged with three counts of criminal damage.

4.46 On 1st November 2012 a call was received from the Ambulance Service at 0349 hours reporting Q was threatening self-harm. On attendance officers could smell gas; therefore, the Fire Service and gas company were appropriately called. Q then came out of the property and was assessed by paramedics. It was established by the Fire Service that damage had been caused to the gas boiler and Q was the only occupant of the premises, therefore the gas board capped the supply. The premises were vented and neighbouring premises were checked as a precaution. No ACN was submitted as Q was taken to the Sunderland Royal Hospital to be assessed. Police periodically checked with the hospital for updates and asked for notification by the hospital if he was released. When officers checked with the hospital at 1500 they were informed that Q had been seen and discharged at approximately 1400.

4.47 At 1551 hours Northumbria Police received a call from a member of the public that a male was sitting on a ledge on the top floor of a multi-storey car park in the centre of Sunderland. On attendance this male was identified as Q and it was reported that he had a bladed article in his left hand. As he was sitting on a ledge directly above a busy street a critical incident was declared and managed by a Superintendent. The street below was closed to pedestrians and buses were diverted, all access to the car park was blocked to the public. Fire and Ambulance Services were both alerted and a Police negotiator was called out. 24/7 response officers, who had been made aware of the incident earlier that day engaged with Q and offered to transport him straight to hospital if he wished.

4.48 After approximately 30 minutes Q agreed to go with officers to hospital and passed some razor blades to them before moving back from the ledge. He was detained under S136 Mental Health Act and taken to Cherry Knowle Hospital where he was admitted. The scene was then stood down. As there were no offences there was no further Police action required. No ACN was raised as per policy to prevent duplication.

4.49 Due to Q's current expression of ongoing suicidal ideation and refusal to engage with Home Based treatment, he agreed to an informal admission to NTW Psychiatric in patient at Cherry Knowle Hospital. Q stayed on the ward one night only, he became angry that the staff were disturbing his sleep when carrying out his planned observations. He was reviewed by the Consultant the following morning and requested his discharge.

4.50 Q denied any current thoughts, plans or intent to harm himself or others and agreed to Home Based Treatment. He was discharged and escorted home by Home Based treatment staff to his address with a plan to visit the following day. The next day Q had contacted paramedics and was taken Accident and Emergency Department after having thoughts to gas and hang himself. Q left the Accident and Emergency Department refusing to be seen. Northumbria Police located Q, who was assessed by Self Harm team and declined interventions and was discharged. Within assessment he informed his thoughts were reactive to being charged with criminal damage and theft and was on bail. The same day Q was found by Police on a multi-storey car park and they took him to the Section 136 suite at Cherry Knowle Hospital (place of safety) and was readmitted.

4.51 Q was then on the ward for 26 days and after five days he was placed on a section 5(2) of Mental Health Act. On that day, he became verbally aggressive with staff, threw a cup of coffee over the ward desk and the Police were called due to his behaviour. He then demanded his discharge from the ward. When assessed by the ward doctor he would not

answer if he would harm himself if discharged. He would not firmly deny whether he would end his life if discharged. He did say that he has thoughts of wanting to harm others and that these are longstanding. Q then absconded, going to a friend's house and was brought back by the Police.

4.52 When officers attended it was established that Q had asked to be discharged, however on assessment the decision was taken to detain him under Section 5(2) of the Mental Health Act. As Q was not happy with this and he forced a window in his room. Officers searched the grounds but did not locate Q and a Missing Form was raised. Q was assessed as a low risk as he was not believed to pose a danger to others or had made any threats of self-harm. That evening a call was received from a female friend of Q who lived a short minute's walk from the hospital reporting that Q was there.

4.53 Officers attended and escorted Q back to Cherry Knowle Hospital. He stated to officers that he had left as he wanted to be discharged and cared for at home. As he had been returned to a place of safety no further Police action was required. No ACN was raised as per policy to prevent duplication.

4.54 On 8th November 2012 Q called Northumbria Police from Cherry Knowle Hospital reporting that he had received threats to kill him from his neighbours and an unknown person had been asking neighbours for his bank card as he owed money. Officers attended and spoke to Q in the presence of a nurse. He stated that he had received third hand information that his neighbours were not happy with him living at his home address due to the recent tyre slashing incident and the self-harm attempt when he damaged the gas boiler. He made no mention of his bank card.

4.55 When officers attempted to give him advice he became abusive and left the room. The nurse reported that he was not on any medication; however, it could not be established if his mental state was such that he could differentiate between fact and fiction. No safeguarding issues or offences were identified and no further Police action was taken. No ACN was raised to prevent duplication due to him already being in the care of mental health practitioners in accordance with the policy.

4.56 On his 11th day as an inpatient Q went on unaccompanied ground leave as per his care plan. He texted a fellow patient several times intimating he was going to self-harm. Northumbria Police were contacted, and a fellow patient was very distressed in respect of the several texts received from him. Q's brother also contacted the ward and there had been no communication with any family member previously as Q's Facebook status was "*rest in peace Q*".

4.57 On this day Northumbria Police received three calls from Cherry Knowle Hospital reporting Q missing. He had left the ward threatening self-harm, and he may have taken some tablets and be in the possession of alcohol. The nearby beach area was searched with a negative result. Further information was received at that Q may still be in the hospital grounds. An officer attended, located Q at the bottom of the drive leading into the hospital and escorted him back into the building. No ACN was raised to prevent duplication as he was already in the care of mental health practitioners.

4.58 A further report was received from security at Sunderland Royal Hospital that Q had gone outside for a cigarette and absconded. On attendance Q had returned and was in the care of a mental health nurse from Cherry Knowle Hospital. A further call was received from the nurse at 1819 reporting that Q had left the hospital and was walking down the road followed by the nurse; however, he had lost sight of him. Officers attended the location where Q had been seen and commenced an area search. He was located nearby and returned to Sunderland Royal Hospital. The Police found Q in the hospital grounds intoxicated, with

paracetamol and whisky, unwilling to accept treatment, he was then placed on Section 2 of Mental Health Act (assessment order).

4.59 In order to prevent any further incidents officers remained with the nurse and Q until he was assessed and detained under the Mental Health Act. There was no further Police action required. No ACN was raised to prevent duplication as he was already in the care of mental health practitioners. It was queried by the Panel whether the efforts of the Northumbria Police were a disproportion amount of time to spend on locating Q when he was, for at least part of the time within the hospital grounds and at time of leaving was believed to have capacity. It was clarified that that the local hospital Missing Persons Operational Policy includes the Northumbria Police 2016 guidance in respect of categories for missing and absent which was implemented in January 2016 and this ensures a robust but proportionate response to missing persons.

4.60 The Section 2 order was rescinded after eight days as there were no depressive or psychotic symptoms expressed, no biological symptoms of depression observed during this admission no thoughts of self-harm nor thoughts of hurting anyone expressed. The diagnosis given at the time was emotionally unstable personality disorder[10].

4.61 The following day there was a further incident of verbal hostility and racist abuse to a patient and Q was confrontational to a staff member. The Police were called and spoke to Q the following day. Q was apologetic for his actions and assured us there will be no further issues. He was made aware that any behaviour perceived to be racist or harassment will be addressed with by the Police service which he accepted. There was another incident of verbal abuse by Q to a staff member and Q threw a full bottle of water when did not receive his medication at night on time. The following seven days on the ward Q was pleasant, chatty, going on day leave with no symptoms observed.

4.62 Q then had an altercation with a staff member and called fellow patients "*nutters*" (sic) which staff felt was inappropriate. Q subsequently recorded conversations with two staff members on his phone and then requested to discharge himself saying that he was taking his recordings to the papers. The Police were contacted regarding the harassment of a staff member. Q was seen by a psychiatrist as he had demanded to take his own discharge. There were no grounds to detain him and Q discharged himself against medical advice and refused Crisis Team intervention. A discharge summary was sent to his last registered GP from the consultant psychiatrist.

4.63 Several attempts were made by CPN to visit at home for his seven-day discharge appointment as per policy. Q was contacted by mobile phone and messages were left. The CPN contacted Q's brother to ask him to encourage Q to make contact with them. Q's brother indicated Q was living in a hostel and was fine. The CPN contacted the GP practice but he had not been to see GP since June and advised they had not been able to make contact for his seven-day discharge appointment. The CPN made an offer to see Q in the future if required, however Q was last seen on 27th November 2012.

4.64 Within assessment Q provided information that he had been subjected to and been historically a perpetrator of domestic abuse. At the time of his involvement with NTW services he was not in a relationship and reported he was living alone in Sunderland. When Q became verbally and physically aggressive towards staff and patients on the psychiatric ward, the Police were contacted, and on their attendance and he was spoken to accordingly.

[10] Borderline (Emotionally Unstable) Personality Disorder is a condition characterised by rapid mood shift, impulsivity, hostility and chaotic social relationships. People with borderline personality disorder usually go from one emotional crisis to another.

4.65 Q was assessed accordingly with the appropriate decisions regarding his care and treatment. Q refused at times to be assessed after alleged overdoses however appropriate decisions were undertaken i.e. to request a Police welfare check after refusal to be assessed at the Accident and Emergency Department. When Q's aggressive behaviour on the ward was difficult to manage the Police were contacted to provide assistance. When Q could not guarantee his safety he was appropriately assessed and sectioned under the Mental Health Act. Q was fully assessed when he wanted to take his own discharge and was deemed not to have capacity and discharged himself against medical advice.

4.66 The Police were contacted regarding Q's criminality when Q was admitted to the ward. The ward staff member was told that he had no outstanding convictions. An alert was put on the red "risk triangle" on Q's health records due to his conviction for stabbing and subsequent prison sentence. Q was difficult to engage post discharge from the ward and the CPN went to great lengths to engage with Q making numerous phone calls, contacting a brother in Stoke-on-Trent and Q's GP. There was an attempt to clarify Q's GP on two occasions, with the last known GP being provided the information of NTW care and treatment. It appears that Q did not register with a GP within Sunderland.

4.67 It was appropriately documented at Q's first visit to the Accident and Emergency Department that he had suffered a recent relationship breakdown however there was never any evidence of domestic violence, either past or present, being an issue at any of these attendances.

4.68 Q was transferred from CHS to the Cherry Knowle Hospital for inpatient mental health care on two occasions and was returned to the Accident and Emergency Department on two subsequent occasions following further episodes of self-harm. Q stated that these episodes had been under the influence of alcohol and his low mood had been exacerbated due to the recent end of his relationship, loss of his employment and 'problems with the Police'. While on occasions Q was reported to be suicidal he had not attempted or wanted to end to end his life and his impulsive behaviour in this regard was reactive to his emotional state.

4.69 Q absconded from CHS on four occasions (two of which were during the same attendance) and Northumbria Police were contacted and attended on three occasions to perform a welfare check and to seek to return Q to hospital for treatment. Q also self-discharged against medical advice from both the Accident and Emergency Department and Acute Medical Unit on four of these occasions. On one occasion an appointment for the Alcohol Liaison Nurse had been made but Q left before staff were able to give him this appointment. However, Q had been assessed as having capacity before he left and had indicated he would see his GP and seek further mental health help.

4.70 Later in 2013 when Q was registered at a GP surgery and the need for support from the Criminal Justice Mental Health Team was re-established, Q declined the offer of services as he now had a flat and therefore indicated he had no need of any further mental health support. However, despite this Q had also asked Stoke-on-Trent Probation to defer a welding course as he could not cope. Therefore, in declining the offer of mental health support Q does not seem to have been challenged by the Probation Officer as he should have been. It would therefore appear that moving home coupled with a new course at the same time suggests that there were issues of resilience which were not addressed.

Effectiveness of response to perceived vulnerabilities

4.71 It was noted that during the period from April 2012 to November 2012 while Q was resident in Sunderland that he had been involved with various services in relation to sexual exploitation, self-harm, violence, criminal damage and mental health issues. There had also been a number of people who had made complaints or allegations against Q which had then been discontinued due to a lack of cooperation or corroborating evidence.

4.72 For example, in July 2012 a neighbour of Q reported that Q assaulted her with a hammer on her shoulder when she confronted him about her missing purse. She later retracted her allegation and Q was therefore released with no further action. However, it was recorded on the incident log that there was a further report that an unknown female stating she was a friend of Q had attended her address and threatened her. There is no record on the log of what action was taken regarding this.

4.73 The female was not identified by the victim and it is therefore possible that there were no investigative opportunities. Further the victim retracted her statement stating she "*didn't want the hassle*". As such Q was released with no further action and the crime closed as undetected as a result of a Police decision based on inconsistencies in the victim's account and her retraction statement. Had there been any corroborating evidence or other witnesses it may have been appropriate to consider whether an evidence led prosecution would have been possible. There may have been opportunities to link this information with other intelligence within the wider partnership discussions.

4.74 Within the discussions held in the Panel it was agreed that a wider partnership discussion should have taken place in Sunderland at that time. It was confirmed that Local Problem Solving Groups had been introduced in 2012 where agencies meet to discuss issues and propose solutions. While individuals were not considered by the group at that time, this has now changed and this type of case where there is a cumulative incidents or offences would now be picked up in Sunderland. There is a now similar process within the Staffordshire Community Safety Partnership processes.

4.75 From the information available to Staffordshire Police at the time of writing their IMR author believes that none of the processes and guidance from preceding years (or even that now offered by the DART approach) would have been capable of identifying the threat Q posed to his half-sister P.

4.76 In December 2013 a brother-in-law to Q reported to the Police that Q was arguing with his fourteen-year-old son, who was Q's nephew, at their home address. Officers attended and the disturbance was attributed to a dispute between Q and the nephew over *"£10 Christmas money*". The fourteen-year-old was stated to have a minor scratch above his eye caused by Q attempting to snatch the £10. It was recorded the fourteen-year-old refused to make a statement and he and his parents did not wish to make a complaint. Q apologised for his actions and stated he should have acted more responsibly.

4.77 Q was 33 years of age at this time. Officers recorded that Q's apology had been accepted by the family and the officers considered this fulfilled the criteria of "*Restorative Justice*". This, coupled with the family's refusal to support a prosecution, led to no further action being taken against Q by the Police. While the application of this resolution satisfied crime recording standards and met the needs of the victim, it is the view of the Overview Author that this should have resulted in a Child Concern Notification being made and a referral to Vulnerable Children and Corporate Parenting. There had been a disclosure of a heated altercation involving a child which resulted in an injury, regardless of how minor, also it appeared the parents having accepted the apology were possibly not taking protective action.

4.78 In August 2014 a member of the public contacted the Police to report two males had vandalised a number of cars parked along a residential street. Following an area search Q and another of his nephews were arrested on suspicion of having caused the damage. However, the allegations were denied and owing to a lack of evidence no further action was taken against Q or his nephew.

4.79 In September 2014 a dispute was reported at the address that was officially recorded as occupied by P's daughter. It was found to be between Q and another of his nephews and during an argument they had begun to push each other and the nephew had sustained a minor cut to his lip.

4.80 The report had been made by a neighbour who wished to remain anonymous. The arrival of the Police stopped the disturbance. Q and his nephew were spoken to and neither of them wished to pursue any complaint and no further action was taken. A crime record was generated for the Police and finalised the record that the victim did not wish to proceed.

4.81 This was an incident between family members but did not sit within the definition for a domestic incident at that time and this would still be the case in accordance with the National Definition adopted by Staffordshire Police. However, this was not the first time Q had inflicted minor injury to one of his younger relatives, although in this instance they were not a child.

4.82 P rang the Police in June 2015 to report that she had been "*kicked out*" of the address she had shared with her partner whom she described as her "*husband*". This had happened about an hour before she had called the Police. She stated she needed to obtain clothing and medication from the address but her partner was refusing to let her in. Police resources became available one hour and 45 minutes later by which time P had left the location. She had been on foot and it was raining.

4.83 On attending the address her ex-partner alleged P had attended his house in a drunken state and he therefore wouldn't let her in. It was recorded within the incident log that her mobile phone "*goes to voicemail, no further message left*". However, there was no record of a voicemail or text message being sent to P, this is of concern as P had spoken of needing medication which included an inhaler.

4.84 It was recorded earlier on the incident log that P stated she would go to her daughter's address, however, there was no record of research about that address and no record of a visit to it. There is also no record of further contact being made with P.

4.85 The incident log was updated the following morning that a DIAL[11] had been completed. This is not supported within other Police records. This response therefore can be considered poor as there was no consideration of the caller's vulnerability and no apparent efforts to establish whether P was safe and well.

Good Practice

4.86 The independent management review reports identified several examples of effective and commendable practice. The panel noted that good practice is that which goes beyond expected practice and agreed the following paragraphs for inclusion in the report.

4.87 Immediately upon receipt of Q's case in Sunderland in August 2008 a discussion was held with Northumbria Police and it was appropriately agreed that Q would be managed as a MAPPA Category 2 Offender. This is highlighted as effective practice and necessary to managing the case correctly.

4.88 Q was visited at his home address on two occasions by his Offender Manager and his then partner, was present during one of these visits in November 2008. This is an example of effective practice to establish any underlying issues at the home address including potential domestic abuse, no such signs were evident at these visits.

4.89 The Offender Manager making the transfer from Staffordshire had reviewed OASys and also completed a Spousal Abuse Risk Assessment (SARA) prior to the transfer formally being completed. This is highlighted as effective practice as these assessments highlight how a period of instability in relationships, lack of employment and excessive alcohol use were risk factors associated with both risk of harm and likelihood of re-offending.

[11] Domestic Incident Assessment Log which is now required for every domestic abuse incident.

4.90 Between August 2013 and mid 2014 it was noted that there was good liaison between Probation and Vulnerable Children and Corporate Parenting in Stoke-on-Trent regarding Q residing with his ex-brother-in-law and his nephew's contact arrangements with his father taking place in the property. Q's anger management concerns also became more apparent in this period. As a result of this liaison children were not allowed in the property while Q was present.

4.91 In January 2015, P attended her GP for a sick note and it is recorded in the notes that P was upset because her housing situation has become more perilous. The GP noted *"I couldn't quite unpick the details but she is at risk she thinks of becoming homeless"*. As well as appropriately providing a sick note and prescription the GP also recorded within P's notes the actions being taken to resolve P's accommodation issues which is noted as effective practice.

5. CONCLUSION

5.1 The review panel commends the way the organisations involved in the review not only provided information and analysed their involvement but also used the opportunity to consider whether there were any improvements required or new ways of working individually and together to ensure that victims of domestic abuse and other vulnerable persons at risk are provided with the most effective and efficient services. Each agency has explored whether their current practice, policy and procedures are fit for purpose and where any improvements are required these are included at Appendix B.

5.2 From information contained in the background information, Management Reviews and summary information it is clear that P and Q's family had several branches, was large, chaotic and with the majority of its members being known to a significant number of services and agencies over a number of years prior to the scope of this review. A long history of alcohol misuse, violence, criminality and domestic abuse spanned the generations on both branches of the family. As children, it appears that P and Q although living in separate households witnessed and were sometimes subject to domestic abuse from an early age.

5.3 Furthermore, other vulnerability issues spanned the generations such as substance misuse. From records, it appeared that both P's parents drank heavily and it is documented that Q used drugs and alcohol while P sought support from her GP regarding her reported alcohol abuse. In addition to domestic abuse, violence, and drug and alcohol use, there were other issues that brought many members of the family to the attention of agencies including child protection concerns, anti-social behaviour and criminal damage.

5.4 Research tells us that children exposed to domestic violence are likely to develop behavioural problems, "*such as regressing, exhibiting out of control behaviour, and imitating behaviours"*[12]. Children may think that violence is an acceptable behaviour within intimate relationships and may become either the abused or the abuser and therefore enters a transgenerational cycle of abuse. Research shows that "*children who witness domestic violence grow up to have a greater risk of living in violent relationships themselves, whether as victims or as perpetrators*".[13].

[12] www.safelives.org.uk/sites/default/files/resources/In_plain_sight_the_evidence_from_children_exposed_to_domestic_abuse.pdf

[13] http://www.urbanchildinstitute.org/articles/features/domestic-violence-an-unwanted-family-legacy

5.5 However, what is also clear is that there was never any indication that Q had idealised, threatened harm to nor would indeed actually murder his own half-sister P. Q was subject to risk assessments while supervised by Probation and was initially assessed as medium risk of serious harm to known adult, also the general public, persons within a close relationship and the Police. Medium risk to prisoners was also added to the category in 2007 and risk to children (due to his anger management issues) was added in 2012. However, this risk was also reassessed on numerous occasions during his supervision period. While there was some criticism within the National Probation Service IMR of an individual's practice in undertaking OASys assessments, at the conclusion of his period of supervision Q was appropriately assessed as medium risk to the public and known adult and in this regard it appeared these risks had lessened.

5.6 Indeed, Q's supervision appeared to end relatively positively and his Probation Officer at the time stated that if he had re-offended using a knife after an extreme emotional arousal against a family member this would have been more understandable. They advised the IMR Author for Stoke-on-Trent Probation that "*it is inexplicable that he re-offended in such a calculating way against his sister about whom he had spoken positively in the past and saw her as a victim in her relationship with her partner*".

5.7 The involvement with Northumbria Police and Staffordshire Police showed evidence of investigation of all lines of enquiry available to them when complaints were made by Q or P. They also progressed investigations into alleged offences committed by Q and secured convictions on a number of occasions. However, none of these were in relation to violence towards members of his immediate household.

5.8 There was also good evidence of inter-agency working between themselves and the other emergency services and health provision when Q's actions were placing himself or others at risk. Indeed, it could be argued that Northumbria Police were acting beyond expected practice when tasking officers to locate Q when he had left the hospital department and was deemed to have capacity. The only point of note was whether there could have been greater consideration of an evidence led prosecution where victims declined to support a complaint or prosecution.

5.9 While the response by Staffordshire Police to P's request for assistance to retrieve her property and medication from her ex-partners in June 2015 was considered poor as there with no consideration of the caller's vulnerability and no apparent efforts to establish whether P was safe and well, this had no bearing on Q's murder of her later the same month.

5.10 In addition, it is clear that during the mental health assessments made of Q during the scope of the review that he had stated while detained under the Mental Health Act that he had long standing thoughts of wanting to harm others. However, there was never any indication that he would act on these or that these were related to any member of his family. Assessment of P's mental health was undertaken at appropriate junctures and referrals were appropriately made for P to the Healthy Minds Network. It was recognised that where people have capacity their engagement with mental health services is voluntary.

5.11 Q refused access to his GP records but there was also never any evidence in P's involvement with her GP practice that she had any concerns about Q harming her. The approach taken by the GP practice in affording P the opportunity to talk about her holistic needs led P to talk about a range of issues including her alcohol misuse, accommodation needs and her son's offending. While there may have been an opportunity to be more proactive with referrals to alcohol misuse services these are voluntary programmes and require commitment and motivation from the individual involved.

5.12 In addition, even if P and Q had resolved their alcohol misuse problems there is nothing to indicate that this would have made any difference to Q's decision to commit murder as even

at times of reported improvement in his use of alcohol there were still episodes of familial dispute involving Q.

5.13 It was also found within the review that in terms of the housing services provided to both Q and P there was never any indication that Q would go on to harm P. There may have been a missed opportunity to provide a multi-agency support plan to Q when he was determined to leave his tenancy before his discharge from hospital in 2012. However, he was encouraged to think about this decision and given his known impulsivity even with sufficient support from a range of agencies this may have not made any difference to his decision to give up his tenancy. Also, this would have had no bearing on his later calculated decision to murder P.

5.14 The review has found that there is evidence of public sector organisations and voluntary agencies with effective policies for the delivery of services for local people and the delivery of those policies has been effective given the presenting issues. There was evidence of knowledge of the multi-agency partnerships to support victims of domestic abuse, managing high risk offenders and safeguard children and vulnerable adults. The review has not identified any lack of understanding regarding which partnership to refer to and when to refer or re-refer a case. While it would not have affected the outcome of this case, the Panel did however believe that due to the variety and cumulative nature of offences and incidents there could have been a more holistic overview of the case through a referral mechanism to MAPPA or a similar forum.

5.15 While there was robust scrutiny and challenge of the information provided to the Panel there was no conclusive evidence found, in records or in face to face discussions that give any insight into Q's motivation or rationale for committing the murder. Indeed, any explanation offered by Q as to this has not been supported by the facts of the case or any other evidence. This clear lack of rationale, motivation or explanation is perhaps not unsurprising given his diagnosis of Borderline (Emotionally Unstable) Personality Disorder which is known to be characterised by '*rapid mood shift, impulsivity, hostility and chaotic social relationships*'.

5.16 It does not appear as if there were any failings in any of the agencies that worked with P and Q to act in accordance with the procedures or practice standards in place at the time. There was evidence of effective communication between agencies and assessment of risk when there were any concerns regarding any potential harm that Q might pose to himself or others. While there were occasions where the totality of information could have been re-examined for wider community safety, there was no existing mechanism to do so. This however, had no bearing on Q's decision to take the life of P. It therefore appears that based on the weight of information provided and the robust analysis undertaken it is considered that the murder of P at the hands of her half-brother Q was neither predictable nor preventable.

6. LESSONS TO BE LEARNED

6.1 The Review Panel identified the following learning within their consideration, scrutiny and analysis of the information provided at Panel.

6.2 Within the consideration of the effectiveness of the multi-agency response to perceived vulnerabilities it is noted had the opportunities been seized for application of referrals of this family including P to the specialists within Staffordshire Police's Public Protection Safeguarding then P could have been signposted for appropriate support and the issues of reviewing and evaluating any process for the management of risk could have been discussed with partner agencies.

6.3 A number of professionals had an opportunity in the course of contacts with this family to discover more about them, including P and Q, which were not pursued. The focus of the professionals involved was on the specific policing task or event and a subsequent resolution at that time. These behaviours impacted throughout the contacts where there was a tendency to underestimate problems. Professionals therefore need to be alert to the risks in relationships and ensure their enquiries are sufficient to evaluate potential risks.

6.4 However, as noted above this was not in relation to any identified or perceived risk from Q to P, but in relation to the multi-agency understanding of the wider picture of P's life and others who may have disengaged from perusing complaints against Q.

6.5 The Panel therefore, considered whether there was evidence of a 'fear factor' in terms of the perpetrator's possible intimidation of other people and the lack of support for complaints and prosecutions. While there was no direct evidence available of this as family members, past complainants or victims were not spoken as part of the review it was highlighted that consideration should be given to evidence led prosecutions being taken forward. This was especially relevant where injured parties did not wish to pursue a complaint and where there is other evidence from body-worn cameras, witnesses or medical records of injuries.

Actions already taken as a result of this learning

6.6 Following a recent HIMC inspection, Staffordshire Police identified gaps in training and knowledge for frontline responders to Domestic incidents. A new training package has therefore been developed in partnership with a nationally renowned academic at the University of Gloucestershire, working with the Home Office, to assist in improving the policing response to domestic violence. The package has been informed from her work with a national charity supporting families through Domestic Homicide Reviews.

6.7 One result of this work is termed the Domestic Abuse Reference Tool (DART) and training in its application is being delivered across Staffordshire Police. DART has a strong focus on coercive control within a domestic relationship. This was designed to assist with the assimilation of the new criminal offence of Coercive and Controlling Behaviour contrary to Section 76 of The Serious Crime Act 2015 which was introduced on the 29th December 2015. Mandatory training has been run from September 2015 by a combination of internal and external trainers.

6.8 The DART training equips officers and staff with a booklet/aide memoire and a perpetrator handout which is now being used across the service. The DIAL risk assessment tool can now be completed via mobile data devices which have been rolled out to practitioners and they are providing feedback that this is an easier process enabling the use of the data more quickly to protect those at risk.

6.9 Staffordshire Police is changing the way it works in areas which include vulnerability and risk. A risk assessment matrix has been piloted for local use in Staffordshire to identify a wide range of vulnerability indicators and risk factors. It is being called the Vulnerability Alert Tool (VAT).

6.10 The VAT is being used in a controlled setting over a trial period within the Force Transformation Programme Prototype at Cannock and Rugeley. The tool is being utilised with monitoring to review its effectiveness. Following the end of the trial period in mid-January 2016 a further review and evaluation took place and a decision made regarding other parts of the force adopting this assessment and identification tool method.

6.11 The tool is a framework by which Police Officers, PCSO's and staff are asked to consider whether any risk factors or indicators of vulnerability are evident or even suspected for the individuals they are dealing with at incidents they attend. The tool then guides them through

a scoring process, which results in a total score for the incident. This is updated onto the STORM serial and, at present, those incidents with a VAT score of 16 or above results in a Vulnerability Alert being activated for that incident log.

6.12 Oversight is maintained of such logs, the action taken is reviewed and liaison takes place with both the officer in charge of the investigation and partners regarding any further action required/referrals that are appropriate and any intervention opportunities that will be in the best interests of all involved.

6.13 This oversight is maintained at a Partnership Hub where a close working relationship is followed with partners from all sectors (including Families First, Local Support Team's, Housing, Health, Care Homes, Fire and Rescue Service, Social Care, Community Psychiatric Nurses, District and County Council).

6.14 Weekly meetings are held with all partners around the table at which they can discuss cases highlighted for further partnership working. The VAT is not done at incidents where a DIAL is required (i.e.; all Domestic and Family incidents), it is one or the other, not both. However, it was noted by the Panel that there is currently no process for cumulative offences or incidents to cross the threshold for discussion at MAPPA or a similar multi-agency forum.

6.15 It was noted that the Real Time Intelligence Team researched any incident that was called in and provided front line officers with all Police information in connection with the parties involved. Tools are available to support the approach which requires support for front line staff to enable them to ascertain why a victim would not want to support a complaint or prosecution. It was confirmed that Staffordshire Police were currently undertaking training in domestic abuse and how to identify the indicators

7. RECOMMENDATIONS

7.1 The Review Panel make the following recommendations:

a. It is recommended that the agencies within the Community Safety Partnership consider a referral mechanism to MAPPA (or a similar forum) where there is evidence that individuals or members of family groups are involved in cumulative offending or incidents of concern to ensure effective multi-agency information sharing, planning and response.

b. It is recommended that training to front line staff ensures they are provided with appropriate tools to ascertain why a victim may not wish to support a complaint or prosecution and to understand the tools available to bring an evidence-led prosecution.

7.2 Recommendations for action to improve their services were also made by the agencies which contributed to this Review. These recommendations are provided at Appendix B. Implementation of action plans arising from recommendations of the Review Panel and the contributing agencies will be monitored under arrangements agreed by the Stoke-on-Trent Responsible Authorities Group. The Responsible Authorities Group will also implement a communications plan which ensures that learning from the Review is effectively disseminated.

Appendix A

DOMESTIC HOMICIDE REVIEW TERMS OF REFERENCE

1 Introduction

1.1 The Terms of Reference for this Domestic Homicide Review (DHR) have been drafted in accordance with the Staffordshire and Stoke-on-Trent Multi-agency Guidance for the Conduct of Domestic Homicide Reviews, hereafter referred to as "the Guidance".

1.2 The relevant Community Safety Partnership (CSP) must conduct a DHR when a death meets the following criterion under the Domestic Violence, Crime and Victims Act (2004) section 9, which states that a domestic homicide review is:
A review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by:

- a person to whom he was related or with whom he was or had been in an intimate personal relationship, or
- a member of the same household as himself,

held with a view to identifying the lessons to be learnt from the death.

1.3 An 'intimate personal relationship' includes relationships between adults who are or have been intimate partners or family members, regardless of gender or sexuality.

1.4 A member of the same household is defined in section 5(4) of the Domestic Violence, Crime and Victims Act [2004] as:

- a person is to be regarded as a "member" of a particular household, even if he does not live in that household, if he visits it so often and for such periods of time that it is reasonable to regard him as a member of it;
- where a victim (V) lived in different households at different times, "the same household as V" refers to the household in which V was living at the time of the act that caused V's death.

1.5 The purpose of undertaking 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 policies and procedures as appropriate; and
- **Prevent** domestic violence homicide and improve service responses for all domestic violence victims and their children through improved intra and inter-agency working.

2 Background:

2.1 The victim and perpetrator were half-siblings and resided together as members of the same household in Stoke-on-Trent. Both were known to agencies in Stoke-on-Trent in connection with domestic violence in previous relationships.

2.2 In June 2015 the perpetrator reported to the Police that he had found the victim deceased at her home address. A murder investigation was commenced by the Police. The perpetrator was one of a number of persons initially detained as part of that investigation.

2.3 Two days after the fatal incident, the perpetrator returned to the Custody Facility in Stoke-on-Trent when he informed officers that he wanted to admit to murder. He was arrested again, interviewed and subsequently charged with murder.

3 Grounds for Commissioning a DHR:

3.1 A DHR Scoping Panel met on 19 August 2015 to consider the circumstances. The Panel agreed that the following criteria for commissioning a Domestic Homicide Review had been met:

CRITERIA:	
There is a death of a person aged 16 or over which has, or appears to have, resulted from violence, abuse or neglect.	**X**
The alleged perpetrator was related to the victim or was, or had been, in an intimate personal relationship with the victim.	**X**
The alleged perpetrator is a member of the same household as the victim	

3.2 The recommendation to commission this Review was endorsed by the Chair of the Stoke-on-Trent Responsible Authorities Group.

4 Scope of the DHR

4.1 The Review should consider in detail the period that commences from 1 May 2012 (four days prior to when the perpetrator first attended Accident and Emergency in Sunderland following a relationship breakdown) until the time of the fatal incident, with the exception of the National Probation Service, where the period commences from 20 March 2006 (when the perpetrator was sentenced to 54 months in prison for wounding) until the time of the fatal incident. The focus of the DHR should be maintained on the following subjects:

Name	P	Q
Relationship	Victim	Perpetrator
Age	46	34
Date of Death	June 2015	N/A
Ethnicity	White British	White British
Address of Victim:	Stoke-on-Trent	

4.2 A review of agency files should be completed (both paper and electronic records); and a detailed chronology of events that fall within the scope of the Domestic Homicide Review should be produced.

4.3 An Overview Report will be prepared in accordance with the Guidance.

5 Individual Management Reviews (IMR)

5.1 Key issues to be addressed within this Domestic Homicide Review are outlined below as agreed by the Scoping Panel. These issues should be considered in the context of the general areas for consideration listed at Appendix 10 of the Guidance.

- Offender management
- Mental health of the alleged perpetrator and effectiveness of services

5.2 Individual Management Reviews are required from the following agencies:

- National Probation Service (Stoke-on-Trent)
- Staffordshire Police
- Stoke-on-Trent City Council - Co-operative Working (Housing Services)

5.3 Individual Management Reviews are required from the following agencies working in other local authority areas with an interest in the homicide:

- City Hospital NHS Foundation Trust - Northumbria
- Gentoo - Sunderland Housing Group
- National Probation Service - North East Division
- Northumberland Tyne and Wear NHS Foundation Trust (mental health and learning disability)
- Northumbria Police

5.3.1 IMR Authors should have no line management responsibility for either the service or the staff who had immediate contact with either the subjects of the DHR or their family members. IMRs should confirm the independence of the author, along with their experience and qualifications.

5.4 Where an agency has had involvement with the victim and alleged perpetrator a single Individual Management Report should be produced.

5.5 Background information and a summary of any significant and relevant events outside of the period considered by the review should be included in the IMR.

5.6 In the event an agency identifies another organisation that had involvement with either the victim or alleged perpetrator, during the scope of the Review; this should be notified immediately to Graeme Drayton, Stoke-on-Trent City Council, to facilitate the prompt commissioning of an IMR / Summary Report.

5.7 Third Party information: Information held in relation to members of the victim's immediate family, should be disclosed where this is in the public interest, and record keepers should ensure that any information disclosed is both necessary and proportionate. All disclosures of information about third parties need to be considered on a case by case basis, and the reasoning for either disclosure or non-disclosure should be fully documented. This applies to all records of NHS commissioned care, whether provided under the NHS or in the independent or voluntary sector.

5.8 Staff Interviews: All staff who have had direct involvement with the subjects within the scope of this Review, should be interviewed for the purposes of the DHR. Interviews should not take place until the agency Commissioning Manager has received written consent from the Police Senior Investigating Officer (and the Independent Police Complaints Commission).

This is to prevent compromise of evidence for any criminal proceedings or potential disciplinary action. Participating agencies are asked to provide the names of staff who should be interviewed to Graeme Drayton, Stoke-on-Trent City Council, who will facilitate this process. Interviews with staff should be conducted in accordance with the Guidance.

5.9 Where staff are the subject of other parallel investigations (including disciplinary enquiries) consideration should be given as to how interviews with staff should be managed. This will be agreed on a case by case basis with the Independent Review Panel Chair, supported by Graeme Drayton, Stoke-on-Trent City Council.

5.10 Individual Management Review reports should be quality assured and authorised by the agency commissioning manager.

6 Summary Reports

6.1 Summary Reports are required from the following agencies:

- NHS England North Midlands (in respect of primary care services)
- North Staffordshire Combined Healthcare
- University Hospitals of North Midlands

6.2 The purpose of the Summary Report is to provide the Overview Report Author with relevant information which places each subject and the events leading to this review into context.

6.3 Summary Reports should be quality assured and authorised by the agency commissioning manager.

6.4 In the event an agency identifies another organisation that had involvement with either the victim or alleged perpetrator, during the scope of the Review; this should be notified immediately to Graeme Drayton, Stoke-on-Trent City Council, to facilitate the prompt commissioning of an IMR / Summary Report.

7 Parallel Investigations:

7.1 Where it is identified during the course of the Review that policies and procedures have not been complied with agencies should consider whether they should initiate an internal disciplinary processes. Should they do so this should be included in the agency's Individual Management Review.

7.2 The IMR report need only identify that consideration has been given to disciplinary issues and if identified have been acted upon accordingly. IMR reports should not include details which would breach the confidentiality of staff.

7.3 The Police Senior Investigating Officer (SIO) should attend all Review Panel meetings during the course of the Review.

7.4 The SIO will act in the capacity of a professional advisor to the Panel, and ensure effective liaison is maintained with both the Coroner and Crown Prosecution Service.

8 Independent Chair and Overview Report Author

8.1 The Review Panel will be chaired and the Overview Report prepared by Chris Few, an Independent Consultant. Mr Few has chaired review panels and written overview reports on behalf of numerous Community Safety Partnerships, Local Safeguarding Children Boards and Local Authorities in connection with Domestic Homicide Reviews and Serious Case Reviews. He has no personal or professional connection with any of the agencies and professionals involved in the events considered by this Review.

9 Domestic Homicide Review Panel

9.1 The Review Panel will comprise senior representatives of the following organisations:

- Arch North Staffordshire
- City Hospital NHS Foundation Trust – Northumbria
- Gentoo – Sunderland Housing Group
- National Probation Service – North East Division
- National Probation Service – Stoke-on-Trent
- NHS England North Midlands (in respect of primary care services)
- Northumberland Tyne and Wear NHS Foundation Trust (mental health and learning disability)
- Northumbria Police
- Staffordshire Police
- Stoke-on-Trent City Council – Co-operative Working (Housing Services)

Communication

9.2 All communication between meetings will be in confirmed in writing and copied to Graeme Drayton, Stoke-on-Trent City Council, to maintain a clear audit trail and accuracy of information shared. Email communication will utilise the secure portal established by Stoke-on-Trent City Council for that purpose.

10 Legal and/or Expert Advice

10.1 Graeme Drayton, Stoke-on-Trent City Council, in consultation with the Independent Review Panel Chair, will identify suitable experts who would be able to assist the Panel in regard to any issues that may arise.

10.2 However, the Individual Management Review Authors should ensure appropriate research relevant to their agency and the circumstances of the case is included within their report.

10.3 The Overview Report will include relevant lessons learnt from research, including making reference to any relevant learning from any previous DHRs and Learning Reviews conducted locally and nationally.

11 Family Engagement

11.1 The Review Panel will keep under consideration arrangements for involving family and social network members in the review process in accordance with the Guidance. Any such engagement will be arranged in consultation with the Police Senior Investigating Officer and,

where relevant, Family Liaison Officer.

11.2 The Independent Review Panel Chair will ensure that at the conclusion of the review the victim's family will be informed of the findings of the review. The Responsible Authorities Group will give consideration to the support needs of family members in connection with publication of the Overview Report.

12 Media Issues

12.1 Whilst the Review is ongoing the Staffordshire Police Media Department will coordinate all requests for information/comment from the media in respect to this case. Press enquiries to partner agencies should be referred to the Police Media Department.

13 Timescales

13.1 The review should be completed and submitted to the Chair of the Responsible Authorities Group by 19 February 2016.

Appendix B

Single agency recommendations

National Probation Service – Staffordshire and Stoke-on-Trent

- When a referral has been accepted by the Criminal Justice Mental Health Team and an offender chooses to later decline these services, even though the officer assesses there is ongoing need, the officer should attempt to set up dissonance/motivate in an attempt to ensure services are taken up.

NHS England

- GPs to be advised to consider recording the name of people who attend a consultation with a patient.

Staffordshire Police

- Training and education of officers and staff should seek to assist them in identifying broader vulnerabilities of adults due to risky behaviour.

Stoke-on-Trent City Council

- Information to be shared between Cooperative Working and external partners more effectively through the use of a “consent to share” form for service users.