Northampton Community Safety Partnership

EXECUTIVE SUMMARY

Under Section 9 of the Domestic Violence Crime

and Victims Act 2004 of a

Domestic Homicide Review
Overview Report
DHR 02

Into the circumstances of the death of

A

aged 57 years in 14th April 2015

Independent Author

Malcolm Ross M.Sc.

December 2016

LIST OF ABBREVIATIONS

ACPO - Association of Chief Police Officers

ACCT - Adult Care Contact Team

AMHPS - Approved Mental Health Practitioner Service

ASB - Anti-Social Behaviour

CATSS - Crisis and Telephone Support Services

CCG - Clinical Commissioning Group

CMHV - Community Mental Health Nurse

CPN - Community Psychiatric Nurse

CRHTT - Crisis Resolution Home Treatment Team

CRO - Community Rehabilitation Order

DAF - Domestic Abuse Forum

DASH - Domestic Abuse, Stalking and Harassment - Risk Identification Tool

DHR - Domestic Homicide Review

DVPO - Domestic Violence Prevention Order

G.P. - General Practitioner

HMAC - Housing and Money Advice Centre

H.M.P. - Her Majesty's Prison

IMR - Individual Management Review

MARAC - Multi-Agency Risk Assessment Conference

NBC - Northampton Borough Council

NCSP - Northampton Community Safety Partnership

NHFT - Northamptonshire Healthcare NHS Foundation Trust

NPH - Northampton Partner Homes

PIP - Support service

SIR - Serious Incident Report (Mental Health)

STT - Short Term Team

YOI - Youth Offenders Institute

Domestic Homicide Review

Into the circumstances of the death of A

aged 57 years in 14th April 2015.

Introduction

This Domestic Homicide Review (DH) examines the circumstances of the death of A, aged 57 years at the time of her death. She was killed by her son, B aged 32 years at the time. He was charged with her murder and has since appeared before the Crown Court on 29th September 2015. B entered a guilty plea to manslaughter on the grounds of diminished responsibility which was accepted by the prosecution. It was agreed in Court that he was suffering from paranoid schizophrenia and auditory hallucinations at the time of the incident.

On 26th November 2015, B appeared before Northampton Crown Court for sentence. He was subject to a hospital order in a secure unit. He was detained under Section 41 Mental Health Act 1983 which will render his likely to recall to hospital should be breach the order.

It will be noticed daughter C specifically requested that the terms Victim and Perpetrator not to be used.

Relevant family members in this case, are represented by the following key:

A - Deceased
B - Deceased's Son
C - Deceased's daughter
D - Deceased' s daughter (deceased)
H1 - A's previous husband
P1 - A's previous partner
Family Friend - A's friend who allegedly abused B

Summary of key events

B had a long history of mental illness and was known to various agencies due to his poor mental health and also his poor physical health.

C was the second eldest child of A. She has an older half-brother. Next are B and then D, who died as a child. A's relationship with the father of the children ended some years ago and little is known about the father. The death of D, according to C, was turning point in A's life.

By the time B was 16 years of age he had been diagnosed with a mental illness. He had taken a drug overdose and was a user of cannabis. He was arrested on 14 occasions, charged with a variety of criminal offences and served a period of time in prison custody.

Police were often called to A's address regarding domestic incidents that would take place between A and B. Officers attended on numerous occasions and the police dealt with the incidents in a variety of ways, usually recording the incidents as a none crime domestic incident. This was in accordance with the policy in force at that time.

C told the Overview Author that B would be punished by his father by being hit, even woken

in the night and hit for something that he had done during the daytime while his father was at work. In 1986 C stated she had reported to the police that her father has allegedly sexually abused her and physically abused B. There was an investigation but there was insufficient evidence to pursue the matter further. During the next few years, B was arrested for damaging his mother's property and also arrested for other matters including attempted robbery and firearms offences.

During the same period of time, A called the police on numerous occasions reporting being assaulted by B. A usually declined to make a formal complaint or follow through a prosecution, no doubt because as a caring mother she did not wish to see her son being arrested. She often requested that B be allowed to return to her flat.

Referrals were made to the Sunflower Centre with a view of offering support to A, but contact between A and the Centre was difficult and often did not happen.

In February 2007, A reported to police that B had caused damage to her property. Officers were despatched but were diverted en-route. She was seen the following day but declined to speak to the officers at the time. They were asked to return at 7.00pm that day but again the officers were diverted and eventually saw A the following day. She did not make a formal complaint. The result of the police action was a referral to the Sunflower Centre.

In June 2007, A again asked the police for help with B who was causing trouble at her flat. She told the operator that she had grandchildren with her, which was not true and seen as a method of trying to encourage a speedy response from the police. Another referral to the Sunflower Centre was the result.

There were two more similar calls from A in January 2008, which had the same result.

In August 2008, A reported that B had threatened her with a knife. Officers removed him to C's house as A did not wish to make a formal complaint.

A similar call was made in December 2008, when the police attended and arrested and charged B for being in possession of offensive weapons, a knife and a knuckleduster.

During October and November 2011, B was arrested again for public order offences. He sought help from his GP regarding his drinking.

Police were called again on a number of occasions during 2012 and 2013 to arguments and reports of assault by B on his mother but on each occasion A was reluctant to make a complaint. She was provided with a safety plan by the police officers, which contain practical advice and are designed to assist in reducing the risk to the victim. A was given the contact details for Women's Aid who made arrangements for a referral to Nene Valley Christian Refuge (now eve). A missed two appointments.

In February 2013, B assaulted his ex-partner and was sentenced to 18 weeks imprisonment and made subject to a restraining order.

In August 2013, A was contacted by the IDVA from the Sunflower Centre. A said it was not convenient to talk at that particular time and requested that the IDVA call back. Four calls were unanswered by A the following day. The IDVA recorded that the threshold for a Multi-Agency Risk Assessment Conference (MARAC) had not been reached. A was having an input from the Domestic Abuse Forum (DAF). As her risk was high her case was passed to the Sunflower Centre to manage and DAF discharged A.

In August 2013, B visited the offices of the Job Centre and made sexualised comments, threats, even threats to kill a particular advisor. The police were called on several occasions but B had either left the premises or he was traced and taken home.

During the Christmas period of 2013, B stabbed himself and he was admitted to hospital where he was for a time in a coma.

Following his discharge from hospital B appeared calmer and his wellbeing had improved. But by April 2014, A was expressing concerns about B's mental stability. She requested that a mental health assessment that was arranged by the N-Step team to be done at her flat by the Community Mental Health Nurse. She was given details of how to contact the AMHP (Approved Mental Health Professional) if she felt B's mental health was deteriorating.

Two days later A called for assistance from the mental health professionals. She was advised to call NHS111. She felt that she was not getting the help she required. The same day B went to see his GP. It was suggested that he be seen at A&E for a mental health assessment.

On 22nd April 2014, B was seen by N-Step. He appeared predominately psychotically driven with evidence of thought disorder. This had been exacerbated by his use of cannabis since he was 11 years of age. He also had significant physical health needs with cardiology and thyroid problems. He was described as being 'floridly psychotic'. He was prescribed anti-psychotic medication which he agreed to take.

In May 2014, B's own flat was burgled and property stolen. He stopped taking his medication and was he was becoming more aggressive. He thought that N-Step staff were trying to poison him and staff felt uncomfortable in his presence. A stopped B seeing her grandchildren.

Arrangements were made for extra security to be installed at B's flat and he was allowed home. But within days A had to call the police due to B aggressive behaviour. A again declined to complete a DASH form, but B was admitted into hospital in Bradford.

A note on file at the Bradford hospital indicated that B should not be discharged to his mother's address as there was a 'complex relationship and her home is no longer an option'.

B was discharged on 9th June 2014. There had been no discharge plan and no communication with A. The community team had not been involved with the discharge and were therefore not involved in supporting access to other appropriate accommodation or services. B went home to his mother who was surprised at his release and stated the following day that she thought he was no better than when he was admitted. This triggered a home visit by a CPN and a consultant from N-Step. They were told that B had not taken his medication. They visited his flat and found it had been broken into and there was no furniture and bare wires hanging from the ceiling where light fittings had been removed.

Housing was contacted to repair the damage at his flat and N-Step supported him. He remained stable.

In September 2014, at the Job Centre B became aggressive with staff after receiving his results from the college. He had also been aggressive in the GP's reception

In October 2014, B became obsessed with an advisor at the Job Centre. He entered the premises when he should not have done so, caused disruption in the reception and made threats to kill the advisor.

Police Officers contacted NHFT concerned that B was presenting a risk to the public and should be taken to hospital or detained under Section 136 Mental Health Act 1988. Police told NHFT that the advisor did not wish to make a formal complaint and N-Step agreed to undertake an assessment.

However the advisor contacted NHFT saying that the police had taken B away and she had not stated that she did not want to make a formal complaint. She stated that B frightens her and that he had gained access to the offices by evading security cameras.

The following day A contacted N-Step saying that B had threatened to kill others and himself. He was detained in hospital under Section 2 Mental Health Act. NHFT contacted the Job Centre on 10th October 2014, stating that B had been admitted and reassured staff that he would not be having any leave.

On 13th November 2014, a consultant psychiatrist and a consultant from N-Step decide that the community forensic team should be involved with B eventual discharge, but stated that there would be no rush to discharge him.

On 1st December 2014, B, having been granted day leave from hospital, was seen at local shops near to the Job Centre offices.

On 10th December 2014, B was discharged whilst he was on day leave. Neither A nor the Job Centre advisor was notified of his release.

C considers that this was not the appropriate time to discharge B, with him being a vulnerable person and Christmas approaching which is a particularly stressful time of year. He received no follow up and no support according to C. B went to stay with his mother.

B failed to keep a number of appointments with mental health professionals in January 2015, although he did see his GP with a foot problem. He stated that he had not collected his medication since he was discharged from hospital and had not taken any medication since that date.

On two days in February 2015, B was seen in the car park of Job Centre trying to get into the advisor's private car. The police were called on both occasions but he had gone by the time they arrived. These matters were recorded as 'no offence' and a notice of information was to be served on him.

In April 2015, he was seen by his CPN at Campbell House. He walked out of the meeting stating that he felt trapped and was being interrogated. It was thought that he needed to be admitted to hospital again for a full assessment. An AMHP attempted to contact two psychiatrists who had been dealing with B in order to admit him to hospital, but neither was available until the following morning. B was going to see his GP that evening. The Job Centre offices were closed and A had stated that she was not going to open her door to B, consequently the risks he posed were considered low. C's view here is that B flat was boarded up following the burglary, where else was he supposed to go other than his mother's flat?

B attended at his GP later that evening. The GP reported to the AMHP that B was calm and comfortable whilst he was in his surgery and stated he did not see anything to cause him concern about B mental state and he could not support a mental health assessment.

In the early hours of the following day, a neighbour of A's called the emergency services to say that he was with B who had beaten A with a pole. Police and ambulance services attended A's flat and found her with unsustainable injuries to her head. She died at the scene.

B was arrested for the murder of his mother.

On 9th October 2015, B appeared before Northampton Crown Court and pleaded guilty to murder on the grounds of diminished responsibility. The plea was accepted by the Prosecution and he was sentenced on 20th October to a hospital order.

Analysis and recommendations

At a Learning Event held on 4th November 2015, practitioners assisted in identifying and discussing several emerging issues which included:

- Opportunities regarding the admission of B into mental health services.

- The absence of a carer's assessment.
- The outcome of risk assessments.
- The victim's rationale to decide not to engage with agencies.
- The recording of incidents by the Police.
- The response of the Police to the Job Centre incidents.
- The potential for victimless prosecutions.

Opportunities regarding the admission of B into mental health services.

NHFT conducted a Serious Incident Review into the Trusts handling of B, in which numerous opportunities to take care of Bin a more positive way were identified. The Trust states that it let B down and he should have been admitted earlier than he was.

Notes on files to the effect that B was not to be discharged to his mother's address were ignored. B was discharged from hospital whilst he was away from the hospital after being allowed a leave day. The community team were not part of the discharge decision or the support plan.

The clinical team were cautious of being with B alone due to his inappropriate conduct to female staff at the Job Centre offices.

There was an absence of any care plan or crisis plan under the Mental Health Act, regarding his non-concordance with his medication. Maintaining treatment with the Home Treatment Team knowing he is non-concordant with his medication is a missed opportunity to return him to hospital. There was also a 'lack of a robust safeguarding approach to the wider family'. A's repeated pleas for B to be admitted into hospital went unheard and the risk he posed to her continued.

There was also a disconnect between what N-Step hoped to gain with the longer use of the Mental Health Act and the constraints of the mental health guidance placed on the AMPH Service in Northampton.

The Serious Incident Review contains numerous recommendations that are included in the NHFT Action plan of this report.

The absence of a carer's assessment.

B was discharged to A's address against the advice of mental health professionals who were dealing with his mental health needs. A had her own needs and did not have the capacity to look after B. She was at risk from him but her 'duty' as a mother not wishing to see her son arrested or hospitalised is understandable, hence her reluctance to assist the police in completing DASH Risk Assessment form or making any formal complaint of assault and criminal damage committed by B.

There is a requirement for a Northamptonshire County wide system to enable agencies to be informed of other agencies working with the same family.

Recommendation No 1

Northampton Community Safety Partnership to consider requesting the Health agencies currently undertaking the Sustainability Transformation Plan Review, to incorporate the issues regarding information exchange identified in this review.

The outcome of risk assessments

The IMR for NHFT found that risk assessments showed that there was a risk from B towards his mother, but that risk assessment was not re-visited when B was discharged from hospital.

Around April 2015, B had been demonstrating unusual behaviour during the day but once he was seen by the GP he appeared calm and comfortable. There was no link between his earlier behaviour and that shown at the GP's surgery. There was too much reliance placed on the GP's comments to the effect that he did not notice anything that would constitute sufficient to section B, particularly considering that the GP was dealing with B physical needs and did not examine B for his mental needs. The need for B to have been admitted that evening should have been escalated by the AMHP.

The risk assessment tool used to evaluate risk, the DASH Risk Assessment Tool, is used by the majority of agencies but it appeared in this case that each agency used the tool in isolation of each other, thereby negating the possibility of having a holistic view of his risk assessment.

Recommendation No 2

Northampton Adult Safeguarding Board to consider commissioning a review of multi-agency training for professionals from all statutory and voluntary agencies on the completion of DASH Risk assessment forms to help ensure a standardised approach when dealing with victims of Domestic Abuse. The training should emphasise the importance of considering previous behaviour which may impact on the escalation of risk. The Adult Safeguarding Board should report to the Community Safety Partnership with the outcomes of the training.

A's rationale to decide not to engage with agencies.

A was discussed at a DAF meeting which is similar to that of a MARAC. However the circumstances did not reach the threshold level for a MARAC, due partly, at that time to the fact that Northamptonshire Police had raised the threshold generally above the national level. In December 2014, the threshold was lowered to conform to national average.

A often declined to make a formal complaint against B and to assist in the submission of a DASH form. There can be numerous reasons why a victim of domestic abuse does not make a formal complaint. In this case it was due to the overwhelming sense of her duty of care for her son, who, it is obvious although being mentally ill, she loved him and wanted to care for him. C told the review Author that her mother would never shut the door on her son and C could not understand why both the police and Family Support Worker told A not to let B into her flat. She raises the question as to where else would he go?

The recording of incidents by the Police

Although there were inconsistencies in approach by officers who attended to calls from A, the majority of calls were recorded in accordance with force policy at that time.

There were occasions when A used the fact that children were at her house when B was causing problems, when in fact the children were not there. It is considered that the use of the children was to ensure a speedy response by the police.

Often substantive criminal offences were reported by A and others, that were committed by B; threats to kill, criminal damage and assaults on A. There is little evidence to suggest that enquiries were made to trace B and investigate these reported offences. When he was traced, it appears that his mental instability was not readily recognised nor any attempt to seek support for him. There were no referrals to Adult Social Care for either B or A.

Recommendation No 3

Northamptonshire Police to ensure that officers are able to recognise vulnerable people and possibly those with mental instability, especially in domestic abuse related incidents, and are equipped with sufficient training and knowledge to make the necessary and correct referrals to support agencies. This will include the appropriate use of Section 136 Mental Health Act 1983.

The response of the Police to the Job Centre incidents

B dealings with the Job Centre offices were of concern. He developed a fixation for the advisor and he explained to C that their hands had accidentally touched on one occasion. He had misread this as a signal of affection. Once he was rejected by the advisor his reaction to her turned threatening and menacing. The advisor was terrified and even moved house, changed her hours of work and used a variety of routes to and from work in case B was watching or following her. This was a serious matter that had a serious effect on the advisor and the staff at the offices.

Police officers were called on a number of occasions and missed the opportunity to consider that his actions were of a person who was mentally unstable and thereby referring him for the appropriate support did not happen.

NHFT also let the advisor down when B was discharged from hospital without any communications with the advisor. B was seen in local shops much to the surprise and fear of the advisor.

The potential for victimless prosecutions.

This case highlights the difficulty of victimless prosecutions when complainants do not support a formal complaint. The Crown Prosecution Service would probably come to the conclusions that there was insufficient evidence to take criminal action against B due to the lack of complaint from A. But in some of the incidents, there were neighbours and other witnesses that may have been traced, who may have been able to give an account sufficient enough for CPS to have considered a different outcome.

Another area that may have been considered was Domestic Violence Protection Orders, but again there is nothing to suggest that the outcome would have been any different if DVPOs had been used.

Northamptonshire Police has invested a great deal of time and effort into training and awareness of the use of the orders, to such an extent that Northamptonshire Police is regularly contacted by other forces wishing to know how the success with DVPOs has been achieved.

B mental health.

B was known to NHFT from April 2014 following the incident when he stabbed himself. On discharge he was referred to N-Step a specialist support service, who supported both B and A.

On being discharged from hospital into the community in June 2014, N-Step had no communication with the hospital enabling his discharge to be planned. He was discharged to his flat which at that time was uninhabitable. He found his way to his mother's address despite her indicating that she was unable to cope with him.

B was constantly non-concordant with his medication which should have been identified as a potential increase in his risk to himself and others.

C stated that when B was released from hospital she took him in to live with her and her five children. She received no support during that period of time and when she could no longer cope B had to move back to his mother's. C feels that she let her brother down.

B was admitted under Section 2 Mental Health Act but this was rescinded in October 2014 without any input from his consultant who considered that B would be concordant with his medication, despite the history of him being so, only when he was detained in hospital.

There is no evidence that the guidance The Care Programme Approach (since changed) which at that time stated that all in-patients should be subject to a care plan, which B would have benefitted from.

His accommodation was totally unsuitable for him to live there. There was nothing to suggest that any consideration of where he was to live was made. Likewise there was nothing to suggest that the safety of A was considered. This lack of joined up communication between in-patient and community setting meant that a robust clinical process for on-going formal treatment of B was not worked through collectively.

Recommendation No 4

NHFT to review the discharge procedure following an admission under Section 2 Mental Health Act, ensuring a more robust system of communication with GPs to avoid delay and therefore potential loss of timely information as well as providing continuity of care provision.

The events of the day before the attack on A have been described above.

There was significant miscommunication within the various areas of mental health with the Heath Authority that was to the detriment of B's care and treatment. History showed that he failed to take his medication unless strictly monitored or detained on a ward. This appeared to have been ignored when he was discharged. It was also clear that his own accommodation was totally unsuitable for him to live in. That coupled with the fact that he had such a reliance on his mother, even though she was often the target of violence and abuse, he was bound to migrate back to her flat and thereby out her safety at risk.

Views of the family

C gave her own views about the manner in which B had been treated, especially by the mental health services. She is of the opinion that B has been mentally ill from a young age starting from when he was abused by his father. She is firm in her view that he needed to be admitted and remain in hospital for longer periods. She points out that he would only take his medication when he was detained in hospital and history showed that he would stop taking his medication when he was discharged. She cannot understand therefore, why he was not detained for longer periods.

Regarding her mother, C describes her as a person who would do anything for anyone – 'she had a heart of gold'. C is clear that A would do anything to stop B going into hospital or into the criminal justice system and her calls to the police were to put a short term stop to B aggression. C feels that A had no intention to see B arrested and charged, hence her reluctance to make a formal complaint and assist in the DASH form process.

On 19th April 2015, the Overview Author and the Interim Senior Safeguarding Project Officer visited C again to discuss with her the final report before it was presented to the Partnership Board. C agreed with the report and its findings and recommendations.

On 25th November 2016, the Author and the Interim Safeguarding Project Officer, visited C at her home and discussed the Overview Report and the Executive Summary with her in detail. She stated that she thought the report was an accurate reflection of the events leading to her mother's death and was also content with the recommendations made in both the Overview report and the IMRs.

Recommendation No 5

Northampton Adult Social Care and Children's Social Care review the needs of C and her family in view of the circumstances of this case and provide any appropriate ongoing care and support required.

A final recommendation is made to ensure that all Overview Report recommendations and action plans are completed as per the Action Plans.

Recommendation No 6

The Northampton Community Safety Partnership Board ensures that agency recommendations contained within this review are implemented by the dates indicated and that each agency confirms with the Partnership that actions have been completed.

Conclusion

The conclusion set out here has been replicated from the Overview Report and is done so to give a full picture of the conclusions the DHR Panel have arrived at after careful consideration of all of the facts in this review.

This is a case where the circumstances are so often repeated and result in domestic homicide reviews. A mentally ill person who is responsible for the death of a parent (usually a mother) where there has been significant domestic abuse by the Perpetrator towards their mother, and the circumstances as being aggravated by alcohol and drugs either illegal or prescribed.

In this case a vulnerable woman who, it is known, sometimes drank to excess, was trying to manage with her mentally ill adult son who used drugs and alcohol and was non-compliant with the medication for both his physical and mental conditions. It is clear that her care for B was foremost in A's mind and during acts of aggression and abuse from him; she called the Police to put an end to that current episode of behaviour. On nearly every occasion she was reluctant to see B being taken away by the Police and prosecuted. She no doubt knew that on each occasion when the aggression was stopped, that there would be another episode sooner or later. The historical pattern of his behaviour indicated that this was obvious, but she did all that she could to protect and care for her son at the risk of being seriously harmed.

There were many opportunities where positive intervention that would have considerably reduced the risk to her was missed by a number of agencies.

The Police response to her numerous calls for assistance was often inadequate. The communication between health, mental health and other supporting agencies was poor. Decision making regarding his admission and discharge from hospital was disjointed and

without thought or consideration for the safety of A. There was no compliance with the requirements of the Care Programme Approach.

It appears that there was little consideration of the historic chronology of either A or B lifestyle and behaviour, which if taken into account may well have influenced their risk assessments. Dealing with events in isolation encourages the 'start again syndrome' where history is not considered.

It is also important to appreciate that in this case, B himself was a victim from a very early age. His life was chaotic and it is alleged that he too suffered physical and sexual abuse at the hands of his closest relatives. His suffering continued until after his arrest for the death of his mother who he idealised. Katz[1] argues that most research into the effects of abuse has on children has concentrated on physical abuse as opposed to coercive control abusive behaviour and that there is now a need to investigate how domestic violence permeates the everyday life of children. B was subject to both physical and sexual abuse as well as coercive controlling abuse in his early life all of which should have been identified as a potential risk to his wellbeing and also the potential of him becoming an offender.

Although outside the scope of this review, it is important to appreciate what happened to B after his arrest. According to C, the mental health team continued to struggle to provide suitable accommodation for B as they had no beds. This culminated in a director calling the police custody suite and without meeting B, he reassessed him as fit and therefore not in need of a bed. This was in direct conflict with the two assessments that had been done whilst he was in custody and face to face with B. The perception of this was that it was purely so the mental health team did not have to house him. C's views are that this demonstrated a continual lack of control and support for him and even the death of his mother did not improve the service provided to him.

Whilst the death of A could not have been predicted, her death could have been prevented. This is supported by the finding of a Mental Health Serious Incident Report that was commissioned by the CCG and concluded in October 2015. The report made 4 recommendations in areas where improvements were deemed to be necessary regarding the use of mental health and cooperation between mental health provisions.

Missed opportunities to have a multi-agency forum and thereby instil some "joined up thinking" and planning around B future may have led to him being subjected to a longer period of detention under the Mental Health Act, a much more robust discharge plan and a more structured care assessment made in respect of A.

Recommendations

Recommendation No 1

Northampton Community Safety Partnership to consider requesting the Health agencies currently undertaking the Sustainability Transformation Plan Review, to incorporate the issues regarding information exchange identified in this review.

Recommendation No 2

Northampton Adult Safeguarding Board to consider commissioning a review of multi-agency training for professionals from all statutory and voluntary agencies on the completion of DASH Risk assessment forms to help ensure a standardised approach when dealing with victims of Domestic Abuse. The training should emphasise the

[1] Beyond the physical incident model: How Children Living with Domestic Violence are Harmed By and Resist Regimes of Coercive Control. Emma Katz Rd. Child Abuse Review February 2016.

importance of considering previous behaviour which may impact on the escalation of risk. The Adult Safeguarding Board should report to the Community Safety Partnership with the outcomes of the training.

Recommendation No 3

Northamptonshire Police to ensure that officers are able to recognise vulnerable people and possibly those with mental instability, especially in domestic abuse related incidents, and are equipped with sufficient training and knowledge to make the necessary and correct referrals to support agencies. This will include the appropriate use of Section 136 Mental Health Act 1983.

Recommendation No 4

NHFT to review the discharge procedure following an admission under Section 2 Mental Health Act, ensuring a more robust system of communication with GPs to avoid delay and therefore potential loss of timely information as well as providing continuity of care provision.

Recommendation No 5

Northampton Adult Social Care and Children's Social Care review the needs of C and her family in view of the circumstances of this case and provide any appropriate ongoing care and support required

Recommendation No 6

The Northampton Community Safety Partnership Board ensure that agency recommendations contained within this review are implemented by the dates indicated and that each agency confirm with the Partnership that actions have been completed.

In addition to the above Overview Recommendations there are numerous agency recommendations contained in Action Plans that will be monitored by the Community Partnership to ensure that the recommendations are implemented within the stated timescales

Malcolm Ross M.Sc.
Independent Chair/Author
Domestic Homicide Reviews
December 2016

Appendix 1

The Domestic Violence Crimes and Victims Act 2004 Section 9 (3), which was implemented with due guidance[2] on 13th April 2011, establishes the statutory basis for a Domestic Homicide Review.

Under this section a 'Domestic Homicide Review' means a review of the circumstances in which the death of a person age 16 or over has, or appears to have, resulted from violence, abuse or neglect by –

(a) A person to whom he was related or with whom he was or had been in an intimate personal relationship, or
(b) a member of the same household as himself, held with a view to identifying the lessons to be learnt from the death

In March 2013, the Government introduced a new cross-government definition of domestic violence and abuse[3], which is designed to ensure a common approach to tackling domestic violence and abuse by different agencies. The new definition states that domestic violence and abuse is:

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

Due to the circumstances of the death of A, the Police informed Northampton Community Safety Partnership. The Partnership decided that the circumstances met the criteria for informing the Home Office that a Domestic Homicide Review was to be commenced. The Home Office agreed and an independent chair and author for the review process was appointed.

The Domestic Homicide Review Panel

The review was carried out by a Domestic Homicide Review Panel made up of representatives of agencies who were involved in delivering services to the family of the victim. It included senior officers of agencies that were involved. The professional designations of the panel members were:

Tenancy Services Manager, Northampton Partnership Homes
Community Safety Partnership Manager, NBC
Designated Nurse Adult Safeguarding, Nene & Corby CCG
Head Protecting Vulnerable Persons Unit, Northampton Police
Named Professional NHS England, Central Midlands
Head Safeguarding Adults, Northamptonshire Healthcare FT
Team Leader, S2S
Chief Executive, eve.

[2] Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews – Home Office 2011 *www.homeoffice.gov.uk/publications/crime/DHR-guidance*
[3] Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews Revised August 2013 Home Office

Service Manager, Sunflower Centre
Interim Senior Safeguarding Project Officer, Business Office
Administrator, Integrated Business Office

None of the panel members had direct dealings with B or his family. The Panel was chaired by an experienced Independent Chair and Overview Report Author. The Chair/author had not had any dealings with B or his family members prior to being involved with this review.

Time Period

It was decided that the review should focus on the period from 2nd October 2000 (the date of the B 18th Birthday) to the date of the A's death on 14th April 2015. However for Education and Children's Social Care the date is extended from 1991, the date that B attended a 'Special School' until 2nd October 2000. The review also considered any relevant information relating to agencies contact with A and B outside the time frame as it impacts on the assessment in relation to this case.

Individual Management Reports

An Individual Management Reports (IMR) and comprehensive chronology was received from the following organisations:

- Northamptonshire Police
- Northamptonshire Healthcare Foundation Trust (to include Berrywood Hospital, Campbell House and CAMHS)
- NHS England – Central Midlands
- Northampton Partnership Homes[4]

Statements of Information were provided by:

- Adult Social Care
- Bridge
- Bradford Hospital
- East Midlands Ambulance Service
- eve
- Woodhill Prison
- John Radcliffe Hospital
- MARAC
- Northampton General Hospital
- People Plus (formerly Action for Employment)
- Probation
- Safeguarding Children's Services (Children's Social Care)

Terms of Reference for the Review

The aim of the DHR is to:

[4] Prior to January 2015, Northampton Partnership Homes was known as Northampton Borough Council Housing Department

- 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 the policies and procedures as appropriate; and

- Prevent domestic homicide and improve service responses for all domestic violence victims and their children through improved intra and inter-agency working.

The Terms of Reference for this DHR are divided into two categories i.e.:

- the generic questions that must be clearly addressed in all IMRs; and
- specific questions which need only be answered by the agency to which they are directed.
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The generic questions are as follows:

1. Were practitioners sensitive to the needs of the victim and the perpetrator, knowledgeable about potential indicators of domestic abuse and aware of what to do if they had concerns about a victim or perpetrator?
2. Was it reasonable to expect them, given their level of training and knowledge, to fulfil these expectations?
3. Did the agency have policies and procedures for risk assessment and risk management for domestic abuse victims or perpetrators (DASH) and were those assessments correctly used in the case of this victim/perpetrator?
4. Did the agency have policies and procedures in place for dealing with concerns about domestic abuse?
5. Were these assessments tools, procedures and policies professionally accepted as being effective? Was the victim subject to a MARAC?
6. Did the agency comply with domestic abuse protocols agreed with other agencies, including any information sharing protocols?
7. What were the key points or opportunities for assessment and decision making in this case?
8. Do assessments and decisions appear to have been reached in an informed and professional way?
9. Did actions or risk management plans fit with the assessment and the decisions made?
10. Were appropriate services offered or provided, or relevant enquiries made in the light of the assessments, given what was known or what should have been known at the time?
11. When, and in what way, were the victim's wishes and feelings ascertained and considered?
12. Is it reasonable to assume that the wishes of the victim should have been known?
13. Was the victim informed of options/choices to make informed decisions?
14. Were they signposted to other agencies?
15. Was anything known about the perpetrator? For example, were they being managed under MAPPA?

16. Had the victim disclosed to anyone and if so, was the response appropriate?
17. Was this information recorded and shared, where appropriate?
18. Were procedures sensitive to the ethnic, cultural, linguistic and religious identities of the victim, the perpetrator and their families?
19. Was consideration for vulnerability and disability necessary?
20. Were Senior Managers or agencies and professionals involved at the appropriate points?
21. Are there other questions that may be appropriate and could add to the content of the case? For example, was the domestic homicide the only one that had been committed in this area for a number of years?
22. Are there ways of working effectively that could be passed on to other organisations or individuals?
23. Are there lessons to be learnt from this case relating to the way in which this agency works to safeguard victims and promote their welfare, or the way it identifies, assesses and manages the risks posed by perpetrators? Where could practice be improved? Are there implications for ways of working, training, management and supervision, working in partnership with other agencies and resources?
24. How accessible were the services for the victim and the perpetrator?
25. To what degree could the homicide have been accurately predicted and prevented?

In addition to the above, some agencies will be asked to respond specifically to individual questions:

- Seek to establish whether the events of 14 April 2015 could have been predicted or prevented. However, it will not establish how the Victim died or who is culpable as this is a matter for Coroner's and the criminal courts.

- Consider specifically agencies' involvement in the period from 2nd October 2000, the date of agencies first known involvement to the death of the Victim on 14th April 2015. Agencies should consider any significant events in this period paying particular focus to any missed opportunities for effective inter and intra-agency working. Agencies should also consider any relevant information prior to this period. If any relevant information emerges previous to this time period this should be notified to the DHR Chair as soon as possible.

- Individual Management Reviews (IMRs) have been requested from each of the agencies defined in Section 9 of the Act, and invite responses from any other relevant agencies or individuals identified through the process of the review. The IMRs should consider the events that occurred, the decisions made, and the actions taken or not taken. Where judgements were made, or actions taken indicate that practice or management could be improved, IMRs should aim to get an understanding not only of what happened but why something did or did not happen. The nature of supervision across agencies should be addressed alongside frontline practice.

- The review should seek to ensure that the review does not impact on or contaminate any other parallel review process including the criminal investigation, mental health investigation or review by National Safeguarding Children Board (NSCB). Issues that arise relating to the

safeguarding of children who may be affected by domestic abuse will be shared with the NSCB.

- The Panel will seek involvement of the families of the Victim and the perpetrator in the review process, taking account of who the family wish to have involved as lead members and to identify other people they think relevant to the review process.

- The review will need to take account of the Coroner's inquest in terms of timing and contact with the family to ensure that agencies, the DHR Panel and the family are able to respond to this review and the inquest avoiding duplication of effort and without undue pressure.

- The Overview Author will produce a report to summarise the chronology of the events and analysis of the actions of involved agencies and any recommendations regarding safeguarding of individuals, families and children where domestic abuse is a feature. It will also give suitable consideration to any equality and diversity issues relevant to both the Victim and the Perpetrator.

- The DHR Panel will aim to produce the report within the time period, subject to responding sensitively to the concerns of the family, particularly in relation to the inquest process, the individual management reviews being completed, the criminal investigation and the identification of issues which may require further review.

- A communication strategy will be agreed that keeps the families informed, if they so wish, throughout the process being sensitive to their wishes, their need for support and any existing arrangements that are in place to do this.

In this case there may be more specific questions we will need to ask of agencies once their IMRs have been received and we have had a look at them, hence the importance of having the Terms of Reference as a standing item on the agenda for each panel meeting.

Individual Needs

Throughout this review process, consideration has been given to the 9 'Protected Characteristics' of the Equality Act 2010. The Home Office Guidance[5] seeks assurance that:

> 'Procedures were sensitive to the ethnic, cultural, linguistic and religious identity of the victim, the perpetrator and their families and consideration for vulnerability and disability was necessary'.

The requirements of this guidance have been adhered to.

Lessons Learned

The Review will take into account any lessons learned from previous Domestic Homicide Reviews as well as Child Protection and Adult Safeguarding reviews and appropriate and relevant research.

The Independent Chair and Author.

[5] Home Office Guidance page 25

Mr Malcolm Ross, was appointed at an early stage, to carry out this function. He is a former Senior Detective Officer with West Midlands Police and has many years' experience in writing over 80 Serious Case Reviews and 25 DHR's as Chair and Author. Prior to this review process he had no involvement either directly or indirectly with the members of the family concerned, the Local Authority or the delivery or management of services by any of the agencies. He has attended the meetings of the panel, the members of which have contributed to the process of the preparation of the Report and have helpfully commented upon it.

Media

All media interest at any time during this review process will be directed to and dealt with by the Chair of the Northampton Community Safety Partnership.

Family Involvement

Home Office Guidance[6] requires that:

> "members of informal support networks, such as friends, family members and colleagues may have detailed knowledge about the victim's experiences. The Review Panel should carefully consider the potential benefits gained by including such individuals from both the victim and perpetrator's networks in the review process. Members of these support networks should be given every opportunity to contribute unless there are exceptional circumstances", and:
>
> "Consideration should also be given at an early stage to working with family liaison officers and Senior Investigating Officers (SIOs) involved in any related police investigation to identify any existing advocates and the position of the family in relation to coming to terms with the homicide."

The family members were have been invited to participate in the review process. C, daughter of A was seen and made a considerable contribution to this review. Her comments are faithfully recorded within the Overview Report. It is stressed however that these views are those of C and may not agree with those of professionals.

These Terms of reference were considered a standing item on Panel Meetings agendas and will be constantly reviewed and amended according as necessary.

[6] Home Office Guidance page 15