Safe Durham Partnership Board

Domestic Homicide Overview Report

An Independent Report concerning
The homicide of Adult A
DHR003

Contents

Section 1: Introduction

1.1 The commissioning of the review
1.2 The review panel
1.3 Reason for conducting the review
1.4 Terms of reference
1.5 Purpose of the review
1.6 Scope of the review
1.7 Subjects of the review
1.8 Objectives
1.9 Background

Section 2: The Facts

2.1 Case specific background
2.2 Chronology
2.3 Genogram
2.4 The Individual Management Reviews (IMR)
2.5 Summary of facts in the case

Section 3: Analysis

3.1 Family involvement and perspective
3.2 Analysis

Section 4: Conclusions & Recommendations

4.1 Conclusions
4.2 Recommendations

Section 1: Introduction

1.1 The commissioning of the review

1.1.1 This overview report has been commissioned by the Safe Durham Partnership Board concerning the homicide of Adult A that occurred in November 2011. This report has been compiled by Mr Russell Wate QPM MSc, supplied by RJW Associates, who is independent of the Safe Durham Partnership and all agencies associated with this overview report. He is a former (retired) senior police detective and his expertise in child protection has received national recognition and he travels internationally presenting courses to healthcare professionals and law enforcement agencies. He is the current Independent Chair of the Peterborough Safeguarding Children's Board (LSCB) and has previously been the Independent Chair of the Hammersmith and Fulham LSCB. RJW Associates have extensive experience in the preparation of IMR's, SCR's and overview reports in a range of disciplines including domestic homicides.

1.1.2 It is important to understand about what happened in this case at the time, to examine the professional's perspective at that time within context although it is likely as a consequence that hindsight will be encountered. This will be rationalised by taking key matters forward in order to broaden professional's awareness both for the future and to ensure that best and current practice is embedded and that any learning is maximised both locally and nationally.

1.1.3 The death of any person in circumstances such as examined herein is a tragedy and in this case the family continue to grieve and to come to terms with the longer term effects. The family of the victim has been consulted during the review process and any of their views are commented upon accordingly within this document. Contact with the family was made by the Independent Chair of the DHR panel, Tom Hunt through the police Family Liaison Officer. The overview author is grateful for this input and the information obtained as a consequence of this contact.

1.1.4 The following agencies have contributed to the Domestic Homicide Review by the provision of reports and chronology. No IMRs have been requested, this follows careful consideration by the Review Chair and Panel. This is due to little or no relevant information being held on either Adult A or Adult B. It was felt that no information existed to explore further within agencies and there were no specific actions for agencies to take forward based on their limited involvement with the family. It was agreed that reports, chronologies and letters would form the basis of the information provided for the overview author.

- Durham Constabulary

- Northumbria Police
- DDES CCG – GP Practice
- Tees Esk and Wear Valleys NHS Foundation Trust (TEWV)

1.2 The review panel

1.2.1 The Chair of the review panel is Tom Hunt, Commercial Director of the County Durham and Darlington Foundation Trust (CDDFT) who is independent of the organisations and agencies contributing to the review. He has no knowledge or association with any of the subjects of this review prior to the commissioning of this review and his appointment as the panel Chair

1.2.2 The DHR panel is made up of membership from the following organisations.

- D/Supt Paul Goundry- Durham Constabulary
- Gill Eshelby- County Durham Youth Offending Service (CDYOS) 1st meeting
- Mark Gurney-Durham County Council, Children and Adults Services
- Gill Findley & Diane Richardson, Durham Dales, Easington and Sedgefield Clinical Commissioning Group- produced GP practice chronology
- Sarah Megan or Carina Carey-Durham Tees Valley Probation Trust
- Margaret Brett-Tees Esk and Wear Valleys NHS Foundation Trust (TEWV)
- Tom Hunt-County Durham and Darlington Foundation Trust
- Tammy Ross-Community Safety Durham County Council

1.3 Reason for conducting the review

1.3.1 A Community Safety Partnership (CSP) has a statutory duty to enquire about the death of persons where domestic abuse forms the background to the homicide and to determine whether or not a review is required. In accordance with the provisions of the Domestic Violence, Crime and Victims Act 2004, Section 9, Domestic Homicide Reviews (DHRs) came into force on 13th April 2011. The act states that a DHR should be 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) 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'

1.3.2 For the purpose of this overview the definition of domestic violence is in accordance with the cross-government definition:[1]

[1] Home Office Statutory Guidance - March 30th 2011

Any incident of threatening behaviour, violence or abuse [psychological, physical, sexual, financial or emotional] between adults who are or have been intimate partners or family members, regardless of gender or sexuality.

1.3.3 The amended definition for domestic violence and abuse was published in March 2013 but is not the basis of this Domestic Homicide Review and Overview due to the date of the commissioning of both the review and overview report. The amended definition 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) 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

1.4 Terms of reference

1.4.1 The Safe Durham Partnership Board identified that in this case the death met the criteria of the act and statutory guidance and commissioned a Domestic Homicide Review (DHR)

1.4.2 The following terms of reference (TOR) has been determined by the Chair of the review panel:

> To establish what lessons are to be learned from the above domestic homicide regarding the way in which local professionals and organisations worked individually and together to safeguard victims. This is the generic principle of a domestic homicide review.

1.4.3 The following additional terms of reference (purpose) were agreed by the panel both for the DHR and form the basis of this overview report.

1.5 Purpose of the review process.

1.5.1 The purpose of the review is to:

- Establish the facts that led to the incident in November 2011 and whether there are any lessons to be learned from the case about the way in which local professionals and agencies worked together to safeguard the family.
- Identify what those lessons are, how they will be acted upon and what is expected to change as a result.
- Establish whether the agencies or inter agency responses were appropriate leading up to and at the time of the incident in November 2011.
- Establish whether agencies have appropriate policies and procedures to respond to domestic abuse and to recommend any changes as a result of the

review process. Domestic Homicide Reviews are not inquiries into how the victim died or who is culpable. That is a matter for coroners and criminal courts.

1.6 The scope of the review

1.6.1 The review will:

- Seek to establish whether the events of November 2011 could have been predicted or prevented.
- Consider the period of 2 calendar years prior to the events, subject to any information emerging that prompts a review of any earlier incidents or events that are relevant.
- Request Individual Management Reviews or reports where appropriate, by 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.
- Seek the involvement of the family to provide a robust analysis of the events.
- The review will recognise that the violence within the relationship of the mother of the perpetrator and the victim had been considered by the Crown Court and was found to have not been influential in the homicide.
- Take account of the Coroners' inquest in terms of timing and contact with the family.
- Produce a report which summarises the chronology of the events, including the actions of involved agencies, analysis and comments on the actions taken and makes any required recommendations regarding safeguarding of families and children where domestic abuse is a feature.
- Aim to produce the report in accordance with the timeline as agreed at panel meetings, respond sensitively to the concerns of the family, particularly in relation to the inquest process, the individual management reviews being completed and the potential for identifying matters which may require further review.

1.6.2 In addition the review will seek to involve the family of both 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.

1.6.3 The review will seek to agree a communication strategy that keeps the families informed, if they so wish, throughout the process. We will be sensitive to their wishes, their need for support and any existing arrangements that are in place to do this.

1.6.4 The review will identify the timescale and process of the Coroner's inquest and ensure that the family are able to respond to this review and the inquest avoiding duplication of effort and without undue pressure.

1.7 The subjects of the review

1.7.1 The subject of this review is the victim, adult A who on the date of his death was aged 37yrs.

1.7.2 The perpetrator is identified as adult B, aged 19yrs on the date of the offence.

1.7.3 The partner of the victim is referenced as AB. The victim and AB have a natural child who is referenced as AC. AB has two children from a former relationship, the perpetrator Adult B and another child, referenced as AD.

1.7.4 Other individuals will be identified accordingly by pseudonym in order to ensure respectful anonymity.

1.8 Objective of the review

1.8.1 The purpose of a Domestic Homicide Review (DHR) is to give an as accurate as possible account of what originally transpired in an agency's response to Adult A, to evaluate it fairly, and if necessary to identify any improvements for future practice. No IMR's have been provided in accordance with the circumstances of the DHR and the direction of the panel and the panel chair. Where it is considered necessary by the author of this report any good and poor practice will be identified accordingly.

1.8.2 This overview report is based on the information commissioned from professionals who are independent from any involvement with the victims, family or the alleged perpetrator. Should actions be necessary by any of the agencies the maintenance of and strategic ownership of any action plan will be the overall responsibility of the Safe Durham Partnership. It is essential that any resulting action plan ownership and any recommended activity is addressed accordingly.

1.8.3 Whilst key issues have been shared with organisations the report will not be disseminated until appropriate clearance has been received from the Home Office Quality Assurance Group. In order to secure agreement, pre-publication drafts of this overview report were seen by the membership of the Review Panel, commissioning officers and the membership of Safe Durham Partnership Board. The associated reports from agencies will not be individually published. The publication of this overview report will be timed in accordance with the conclusion of any related proceedings and any other review process, and after the appropriate clearance from the Home Office Quality Assurance panel. The (redacted) DHR overview report will be made public and the recommendations will be acted upon by all agencies, in order to ensure that any lessons of the review are learned.

1.8.4 Relevant family members of the victim will be briefed about the report in accordance with policy and practice of the Safe Durham partnership board and such consultation should take place prior to publication of the report.

1.8.5 The overview author is conscious that this report may contain some distressing information for the family of the deceased and care will be taken to ensure that any concern will be addressed accordingly and the family's wishes will be taken into account.

1.9 Background

1.9.1 In 2011 and 2012 a total of 540 murders were committed in England and Wales. Of these 176 were identified as being 'domestic homicides'[2]. Historically, very few domestic related homicides were reviewed leaving a potential gap in professional knowledge. In 2011 the Home Office published the Multi-Agency Statutory Guidance for the conduct of Domestic Homicide Reviews. The legislation became effective as of April 11th 2011.

1.9.2 The Safe Durham Partnership was formed in April 2009 following Local Government Reorganisation. Prior to this there was a long history of partnership working across County Durham at both a countywide level and through the five districts/borough based Community Safety Partnerships[3]. The vision is for a County where every adult and child will be, and will feel, safe. Working in partnership is essential in order to achieve this vision. There is a strong history of partnership working across County Durham since the introduction of the Crime and Disorder Act in 1998. A commitment to working in partnership has ensured real and tangible improvements to the quality of life of their communities[4].

1.9.3 Crime in County Durham is currently at its lowest levels since 1983 and has a crime rate well below the average for England & Wales. Repeat victimisation rate for domestic abuse remains well below the target set by the Home Office. Levels of domestic abuse related incidents reported to the police have remained relatively stable with 10,209 incidents in 2009/10, 10,425 in 2010/11, 10,865 in 2011/12 and 11,084 in 2012/13.

1.9.4 The Safe Durham Partnership is committed to preventing crimes against vulnerable people, but where they do occur it will provide them with support. They will also take strong enforcement action against perpetrators. The repeat rate of Domestic Violence for cases subject to the Multi-Agency Risk Assessment Conference (MARAC) process is low in County Durham. Reducing repeat victimisation for high risk cases is a key role for the Safe Durham Partnership which has ensured that MARAC has been implemented across all of County Durham. The Partnership is committed to creating a culture where domestic abuse victims have the information and confidence to ask for help.

1.9.5 Alcohol harm reduction is also a priority for the partnership. Alcohol was identified as a significant factor that cuts across all other priorities. Alcohol and

---

[2] In accordance with the definition of a 'domestic homicide' at that time.

[3] Although CSP's continue to exist, this process will be reviewed by the respective PCC's.

[4] Safe Durham Partnership plan 2011-2014

substance misuse are problematic in their own right and aggravate other crimes and disorder. They can lead to people becoming more vulnerable to offences of assault, while many victims of abusive partners suffer with personal substance misuse.

1.9.6 Within the Safe Durham Partnership Plan for 2011-14 are two areas that are of particular relevance to this review:

- Improve the safety of victims and reduce repeat incidents of domestic abuse.
- Reduce the harm caused by alcohol.

1.9.7 It is because of the strong commitments and clearly successful partnership working as highlighted in this plan, that the overview author is confident that any recommendations on lessons that need to be learned from this DHR will be acted on accordingly.

Section 2: The Facts

2.1 Case specific background

2.1.1 The victim, Adult A lived in a former colliery town in the North of the County of Durham with his partner of some ten years, AB and their daughter AC. They were not married but had lived together as a family over that time. Also living with them were AB's children from a previous relationship, who were the perpetrator Adult B and his sibling AD. The victim was the proprietor of a local business. AB was in the process of training as a specialist healthcare professional.

2.1.2 In the early hours in November 2011, the perpetrator, Adult B who had been drinking heavily up until that point, attacked the victim with a kitchen knife. This was following an apparent family argument during which time he had intervened and had been repeatedly asked to leave the house by both AB and AD. The victim had also been drinking prior to the attack taking place.

2.1.3 The victim was stabbed five times in the chest and despite medical intervention at the scene he died short after admission to hospital. The entire incident took place within the house that the family had all resided at for a number of years.

2.1.4 The perpetrator pleaded guilty to Manslaughter however this plea was not accepted by the prosecution. Adult B claimed provocation as part of his defence, stating that the victim was controlling and manipulative and cited the relationship between Adult A and AB as part of that defence. Following a trial he was convicted of murder and was sentenced to a term of life imprisonment with a minimum tariff of 17 years.

2.1.5 The perpetrator had claimed that over many years of the relationship between the victim and AB, that he had witnessed numerous extreme disputes, claiming that this was in fact domestic abuse on the part of the victim. This perspective caused the trial to explore the background of the victim, which the family of Adult A found particularly

upsetting and distressing. The jury at the trial rejected this explanation and as stated he was convicted, this overview report respects this conviction and is written accordingly.

2.1.6 The perpetrator received an 18 month concurrent prison sentence at the same time as the murder conviction for an un-related offence of violence where a weapon had also been used by him during an altercation which had occurred in the same geographical area. Adult B had also previously come to notice in circumstances of violence and instances of anti-social disturbance.

2.1.7 In passing sentence, the trial Judge said: *"It was a needless loss of life for which you are responsible. It is yet another example of the consequences of someone disinhibited by drink, arming himself with a knife and intending to use it".*

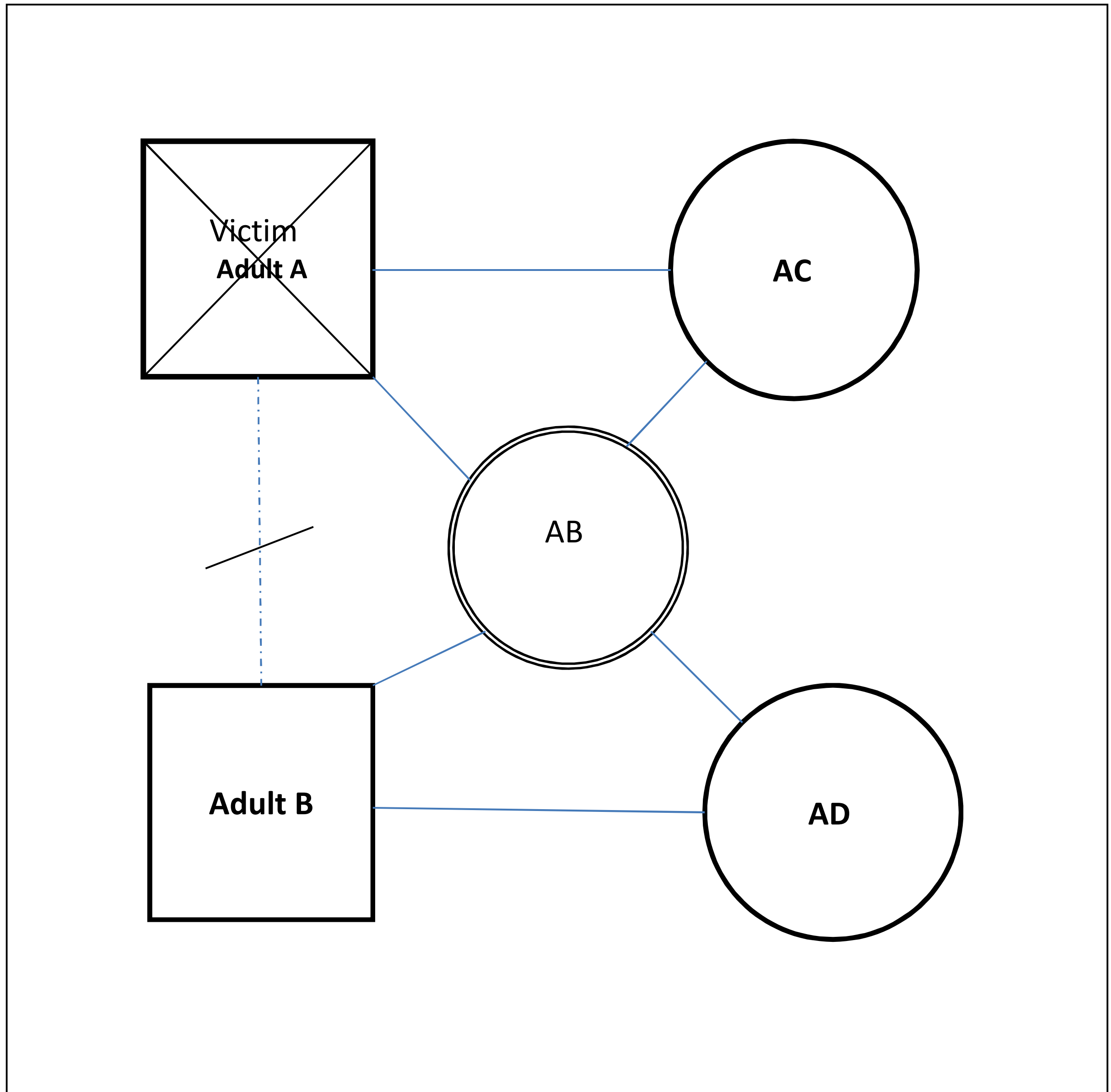
2.1.8 The family have been offered through the family liaison officer, contact with the panel chair of the review, however this offer has been declined. The partner of the victim, who is also the natural mother of the perpetrator and her daughter have very raw emotions and the overview author recognises that in effect they have lost two members of the family through one single tragic event.

2.1.9 The family were also offered the opportunity to submit a written response to the consultation should they prefer to do so. This was also declined. The overview author fully appreciates their standpoint. They have since moved away from the area.

2.2 Chronology

2.2.1 The overview author is grateful for the chronologies submitted by the respective agencies which have assisted in the compilation of this report. The respective chronologies are not reproduced for the purpose of this overview report.

2.3 Genogram



			X			———	Enduring Relationship
						- - - -	Transitory relationship
Female	Male	Pregnancy	Abortion or Miscarriage	Deceased – Cross is placed inside gender symbol	Subject	/	Separation
						//	Divorce

2.4 The Individual Management Reviews (IMR)

2.4.1 In this case, after very careful consideration by the Domestic Homicide Review Board and the Review Panel, Chair of the Panel and the independent author, IMRs have not been commissioned from individual agencies. The reason for this was that very little or no relevant information is held on any individuals included within the scope of the review. It was mutually agreed that reports, chronologies and letters would form the basis of the information provided for the overview author.

2.4.2 No specific comment is raised concerning the individual submissions made to the overview author

2.5 Summary of facts in the case

2.5.1 It is a fact that Adult B was convicted of the murder of Adult A in July 2012, for which he had received a life sentence with a minimum tariff of 17 years imprisonment. Adult B had originally pleaded guilty to an offence of manslaughter and during his trial for the murder, his defence painted what appears to have been a distorted and not believed image of the victim in particular the relationship between the victim and Adult AB.

2.5.2 This was an unprovoked attack where the victim was the only person attacked although AD received an injury during the attack as she made efforts to prevent Adult B attacking Adult A. Also present at that time was AB. AC was also present in the household at the time.

2.5.3 Adult A and AB had been in a relationship for approximately ten years and had a young child, AC, half-sibling to the perpetrator. AB also had another older child, AD, the younger sibling of Adult B. The family lived together in a residential part of the town where the offence occurred and where Adult A's business was based.

2.5.4 Late on the evening in November 2011, Adult B was at home with Adult A and AB. He had been drinking during the evening with Adult A, during which time it is suggested that he had consumed a large quantity of alcohol and he found his mother and the victim in the process of an argument. Adult B intervened and despite the pleadings of AB and his own sibling AD, he attacked Adult A, stabbing him several times with a kitchen knife, before fleeing the scene shortly after midnight. Adult A was taken to hospital but sadly died from his injuries within a short time of his admission. The weapon used was not recovered.

2.5.5 At the time of the incident, the initially attending police officers were told by the family, at the behest of the perpetrator that the attack was carried out by two masked intruders, who attacked the victim and fled. The injury to AD was alleged to have been caused when she intervened in the attack. As events unfolded, the police established that an earlier disturbance had been heard in the house by neighbours and as a

consequence, Adult B together with AB and AD, were all arrested for murder. At the point of arrest, Adult B admitted that he was responsible.

2.5.6 As a consequence of the initial account given to the officers, all 3 were arrested and held in custody. AB and AD provided truthful accounts of what had occurred and were released with them becoming significant witnesses. No charges were made against them. Adult B was charged with the murder.

2.5.7 On the evening of the murder, Adult A & B had been at the house and had been drinking champagne and lager. Adult B was described as being drunk and had vomited on a number of occasions.

2.5.8 The victim and AB were arguing and both AD, followed by Adult B, had gone downstairs to see what was happening. Adult B was becoming agitated with Adult A due to his arguing with his mother. It was during this that Adult B took a knife from the kitchen and despite pleas from AB and AD, he attacked and repeatedly punched Adult A and then removed the knife, which he had secreted in his underpants and stabbed the victim who was left unconscious on the floor of the living room. Adult A then pleaded with AB and AD to make up a version of how it had happened.

2.5.9 At the time of the murder, Adult B was on bail and awaiting trial for an offence of violence where he had allegedly attacked the victim in that case, with a knuckleduster and had then kicked and punched him on the ground. He was not the sole attacker in that case, where the victim had suffered serious head and facial injuries amounting to grievous bodily harm. That offence had occurred less than 3 months earlier, in August 2011. There was no causal link between that offence and the murder.

2.5.10 In examining the unrelated incident, Adult B's bail conditions stemmed from his arrest for the offence of grievous bodily harm which took place in August 2011 and he was later remanded [on police bail] in September 2011. As part of those bail conditions he was required to reside (to live and sleep) at an address out of the area where the offence took place. This condition of residence meant that he should not have resided at the home of Adult A and AB or have been in the geographical area in November 2011. Those conditions remained in place at the time of the attack on Adult A. It is not clear as to whether or not that the family were aware of his bail conditions.

2.5.11 The home of the victim and AB was within the area that his bail conditions were intended to restrict his movements to, for the protection of the witnesses and victim in that case. It is not clear from the information provided to the overview author how or why Adult B was at Adult A and AB's home at the time or where he had been in the period immediately prior to the incident.

2.5.12 Although not clarified, the overview author is able to state, that individual breach of bail conditions, whether from conditional bail that is imposed by the police, or by judicial authority, are not uncommon.

2.5.13 Decisions to impose bail conditions are not taken lightly and are by their nature, intended to protect both victims and witnesses and reduce or prevent the likelihood of further offending by the bail subject. They also allow some freedom of movement by the bail subject in accordance with their lawful rights.[5] Checks made of individuals on bail, is a subjective matter although the police occasionally carry out random or specified checks and respond to information and intelligence concerning breaches of bail.

2.5.14 In every instance the Officer In Charge will risk assess the likelihood of the suspect breaching the imposed bail conditions. In this particular instance the OIC considered the following in their decision making:

- The residency/sleep condition was the only bail condition where they could carry out a check;
- The condition to remain out of a particular area was being policed by markers on the Adult B in the intelligence system and PNC;
- The bail address was the Adult B's father's address, which was his usual home address and was in another police force area;
- Adult B had fully co-operated with the police investigation;
- That co-operation included an admission to the assault;
- The OIC did not consider resource implications as a factor particularly given that the resource would have fallen to another force, and experience shows that this force would have carried out such a check if requested to do so.

2.5.15 In considering the above the OIC felt that it was reasonable to not require a bail check in this particular instance. However as is made clear, if it was felt necessary, based on the presenting risks, a bail check would have been carried out.

2.5.16 The background of Adult B indicates that acts of violence, such as exemplified within the incident in August 2011, were not unusual.

2.5.17 In January 2011, in an incident that had occurred in another police force area, Adult B was arrested by officers, having been allegedly involved in an incident and disturbance where a man was pursued by attackers reportedly wielding machetes and swords. When enquiries were made by officers within the locality of the reported disturbances, it was ascertained that Adult B had taken possession of a knife when he had left a nearby address, returning it a short time later and handing it to the occupier.

2.5.18 When detained by officers in that incident, Adult B was in the vicinity of the incidents and when found he had traces of blood on his clothing. A second man was also detained concerning the same circumstances. Despite some limited testimony, Adult B was not charged, following charging advice as the threshold test for prosecution had not been met[6]. Adult B declined to make comment in interview as to what had occurred. Despite enquiries the full circumstances of the incident could not be

[5] Human Rights articles and the right of presumption of innocence of an accused.

[6] Decisions that are made by suitably trained and experienced police officers and/or the Crown Prosecution Service, based on nationally published CPS codes and guidance.

determined and no action was taken against him. The overview author has examined the records of this report and fully endorses the perspective taken by the authorities based upon national guidance.

2.5.19 The only other relevant information known concerning Adult B was presented by the Tees Esk and Wear Valley NHS Foundation Trust (TEWV), the Mental Health Provider.

2.5.20 In August 2010, Adult B was admitted to hospital having taken an overdose of Tramadol tablets. The referring house officer considered that he showed 'possible' symptoms of schizophrenia and an assessment by the TEWV mental health crisis team was sought. Adult B was however not suitable to be seen as an in-patient by the TEWV crisis team due to his treatment for the overdose and that his state of mind would not present a true picture for a proper assessment.

2.5.21 Adult B was however seen the following day at his home, following his discharge from hospital. He indicated that the 'overdose' was triggered by what he considered to be *"family stresses",* which he cited as being him feeling pressurised by his mother and step-father to leave the family home and get a job. The report indicates that at the time of this visit there were "*no signs of depression or mental disorder".*
2.5.22 There is no information concerning other family members or engagement with them at this time or otherwise.

2.5.23 There is no record of any treatment or further clinical intervention or support to Adult B following this incident.

2.5.24 In respect of the victim Adult A, there is no information of relevance concerning him held by any agency for the purpose of this overview report within the specified review period.

2.5.25 There are no parallel proceedings in this case. The inquest into the death was opened and adjourned pending the result of the murder investigation and the criminal trial. The HM Coroner for the area has formally closed the inquest in view of the conviction for murder.

Section 3: Analysis

3.1 Family involvement and perspective

3.1.1 The Chair of the DHR panel, Tom Hunt, made contact with AB, the partner of Adult A and also AD through the police Family Liaison Officer (FLO) although grateful for the consultation, both declined to meet with the Chair and consequently there is no family input to the review. Through the FLO contact has also been made with other associated members of the victim's family but they also declined to be involved in the review process.

3.1.2 The overview acknowledges the fact that both AB and AD were arrested at the time of the offence in what must have been traumatic circumstances. This has undoubtedly had a profound effect on them. They have moved away from the area to try and get on with their lives and the overview author agrees to respect their wishes.

3.1.3 The overview accepts entirely their perspective and is sympathetic for the terrible loss suffered by all aspects of the family. Should the family wish to make any form of submission to the overview, this will be welcomed and evaluated by the overview author in order to integrate to the final report. The overview author has expressed his willingness to also meet with the family should they consider that this would be of benefit to them, in order to discuss the findings of the DHR.

3.1.4 The Review Panel and Chair respectively acknowledge that family members declined the offer of involvement into this DHR. Due to this, little information is available to the author to allow for them to draw out further information or personal traits of either Adult A or Adult B, which would have further benefited the narrative of the report.

3.2 Analysis

3.2.1 In analysing the facts of the case the Review Panel and Chair felt that there were risk factors in relation to Adult B, which included previous acts of violence, the previous use of alcohol as a disinhibitor, previous mental health issues and the breach of the bail condition. These risk factors are discussed in more detail further below.

3.2.2 Reports from Durham Constabulary showed that Adult B was a young man who clearly had a violent nature, not just exemplified as a consequence of this tragedy, but also in his admission of the previous assault in August 2011, for which he was on bail for at the time of the murder.

3.2.3 Adult B had been drinking at the time of the murder of Adult A. The overview author has not been presented with any additional factual information and consequently cannot comment further with any authority as to the significance of the effects that alcohol played in the previous incidents of January and August 2011.

3.2.4 In passing sentence for the murder, the Recorder of Newcastle, said:
"It was a needless loss of life for which you are responsible. It is yet another example of the consequences of someone disinhibited by drink, arming himself with a knife and intending to use it". He further added,
"You are an intelligent young man and, although I have no doubt you regretted your actions after you realised the seriousness of what you had done, you are neither naive, nor particularly immature for your age and you clearly have a vicious temper."

3.2.5 How much a factor that alcohol played in this particular case is of course not known, but matters within the public domain, as articulated by the trial judge, identify that this was

a factor in this case and evidence would indicate that Adult B had been drinking excessively in the immediacy of the tragic events of November 2011.

3.2.6 However there is nothing apparent to the overview author that indicates that opportunities to address the effects of excessive alcohol consumption were or should have been recognised in this case. Those generally perhaps ‘best placed’ to identify such issues may invariably be the police and healthcare professionals, however there is no information to indicate that the perpetrator was an obvious risk to others through the excessive use of alcohol or that had been identified by those or indeed any other agency.

3.2.7 In 2010 Adult B was assessed by TEWV, the Mental Health Provider, following an overdose. The report indicates that at the time of the assessment there were “no signs of depression or mental disorder”. There is no record of any treatment or further clinical intervention or support to Adult B following this incident.

3.2.8 At the time of the murder, Adult B was on bail for another offence of violence. Although this was not an individual act, it was one of significant violence where a weapon was used. There is also evidence that suggests the perpetrators propensity to arm himself, such as in the incident in January 2011, which, although not prosecuted, indicates that he was not averse to using a weapon.

3.2.9 Adult B was certainly aware that he was on bail and would have been aware that he was in breach of his conditions by residing in the family home. It is not clear whether his family knew of his bail conditions. A check was not carried out on Adult B’s bail address as the risk of this individual was deemed as not requiring a bail check by the OIC in this particular case, which was a reasonable decision to make based on the presenting facts of the case.

3.2.10 It would have benefited the narrative of the review to include additional information to draw out who Adult A and Adult B were and the dynamics of the household around the time of the incident. However due to the sensitivities of the case, the family felt that they did not wish to contribute to the review process. Therefore this further information was not available to the Panel, Chair or Author. The Panel and Chair respects the wishes of the family in doing this.

3.2.11 It is possible, although there is no evidence presented to the overview author, that Adult B may have been a dominant force within the family unit and that under such circumstances, the family were thus unable to have any influence upon him within the domestic environment. There is no evidence of any domestic abuse within this household that has been presented to the DHR process.
3.2.12 The overview author has not seen any evidence or information that the ethnicity or cultural background of either the victim or the perpetrator has any relevancy to the circumstances of this case. The overview is satisfied that these issues have been adequately addressed within the relevant reports.

Section 4: Conclusions & Recommendations

4.1 Conclusions

4.1.1 The overview report has not been presented with any information or evidence that suggests that the tragic events in November 2011 could actually have been predicted. The evidence within the DHR reports and of the Court proceedings indicate that the events were as a consequence of a sudden, but nevertheless unprecedented and intentional act of extreme violence towards a family member by the perpetrator.

4.1.2 The response to the question could the murder have been prevented given the facts as are known by the overview author, the answer would have to be no.

4.1.3 Adult B was on bail at the time of the murder, for an offence of violence against a person. This was a serious allegation and of a relatively recent occurrence. The circumstances of the attack show that extreme violence using weapons was used by Adult B although it did also involve others. He was, as such, a risk to persons purely from his antecedents as known at that time.

4.1.4 Adult B was on bail in order to ensure that the chances of his further offending, in principle towards the victim and witnesses in that particular case, were reduced by appropriately considered, lawful and effective bail conditions. The conditions were known to the perpetrator and agreed by him in order to allow that his rights were considered and observed. As such he could have been under no misapprehension of what was required of him in order to comply with those conditions.

4.1.5 The justification for the process of bail is subjective, keeping in mind the principles of justice, the need to ensure an effective investigation and the protection of witnesses. In terms of pre-charge bail, it is important that the police are given time to investigate the criminal allegations and to try to ensure that the suspect returns to answer to those continued enquiries. In regard to post-charge bail, it is important to consider that the defendant does not go on the run and miss the court hearing, intimidate witnesses or potential witnesses. Bail conditions are therefore not taken lightly and are focused to the case specific needs. In essence bail conditions are not imposed unless it is considered necessary.

4.1.6 The mechanism for checking or ensuring that bail is adhered to is a subjective test. It would be wholly impracticable for a police force or for other agencies charged with this duty to complete this as part of any core responsibility or expectation. Where necessary, bail checks are occasionally carried out by the police and will generally be on a case by case basis, or part of a wider and targeted process. To check individual cases on a regular basis is not a realistic proposition and would need to be resource intense. There will be occasions where such checks are conducted, however not in this case as there was no apparent necessity.

4.1.7 Specifically in this case, Adult B, who was on bail with conditions, would not ordinarily have been checked by officers in order to ensure compliance with the conditions.

Had an incident occurred involving Adult B, it would have been more likely that those bail conditions would have been scrutinised accordingly. A check was not carried out on Adult B's bail address as the risk of this individual was deemed as not requiring a bail check by the OIC in this particular case, which was a reasonable decision to make based on the presenting facts of the case.

4.1.8 A breach of conditions however will not always culminate with the subject being detained and would be based upon the actual circumstances at the time of the alleged breach.

4.1.9 In this case there is no evidence or information that indicates that Adult B was or had been persistently breaching his bail conditions prior to the murder.

4.1.10 In his trial defence, Adult B attempted to deflect the case to the detriment of the victim. This was fully tested in evidence at the trial and it is apparent that this failed. There has been no information or evidence presented to the overview author that would suggest that there was any significant background to the relationship between the victim and AB as claimed by Adult B. The family of the victim have clarified their perspective immediately following the trial and qualified that this was, in their considered belief, an attempt to smear his good nature.

4.1.11 Despite the fact that the perpetrator was on conditional bail, there is no information presented to the overview that gave any indication that he would breach his conditions and place others at risk or potential risk, in particular Adult A.

4.1.12 The overview report does however make the observation that had Adult B have been in compliance with his imposed conditions in November 2011, the murder may not have occurred as the residential condition was that he should not have been at the home of the victim at that time.

4.1.13 This fact was far outside of any agencies knowledge at that specific time. It may have been a fact within the knowledge of the family, however this cannot be confirmed.

4.2 Recommendations

4.2.1 This overview report will be shared with Durham's Children and Adult Safeguarding Boards for them to ensure relevant issues and learning are taken forward by each of them.

4.2.2 Two of the offences of violence preceding this tragedy suggested that the perpetrator had possession of weapons, respectively a knuckleduster and a knife. It is a known fact that the weapon used in the murder of the victim was a knife although this was not recovered.

4.2.3 Police forces within the UK do from time to time and in recognition of the type and levels of violent crime prevalent at the time, support the use of weapons amnesties. This does not identify who was in possession of the weapon at that time and as such encourages some individuals to come forward and hand in illegally held weapons, such as bladed

articles, firearms and other prohibited items into secure containers, strategically located within pre-determined areas.

4.2.4
Recommendation 1:
The DHR review panel recommends that the Safe Durham Partnership explores the opportunities for agencies to undertake a weapons amnesty in targeted areas of the County.

Although accepted that a kitchen knife was used in this case, but a weapon was used in previous offending by the offender. It is appreciated that the success of this cannot be judged by the actual reduction of crimes of violence, it is likely to reduce the circulation of a number of dangerous and also prohibited weapons within the community and encourage those who would otherwise retain such weapons from a perspective of fear or concern of prosecution, to surrender them without prejudice.

4.2.5
Recommendation 2:
a) The SDP asks the Durham Constabulary to consider where individuals are subject to bail for crimes of violence (GBH) Officers In Charge of an investigation proactively consider and document rationale for their decision that a formal letter is handed to the suspect/defendant.

This letter is endorsed by the Police/Courts/Probation and other relevant agencies working in partnership, notifying the individual of the steps that will be taken in the event of information or indication that the subject is in breach of any of the specified conditions.

Although warnings are given verbally at the time of bail, the consequences of the breaches should be more overtly addressed by a partnership approach as a way of reducing and making efforts to re-enforce that any grant of bail with conditions is not a step that is taken lightly by the judicial process. There will need to be an awareness programme to implement this initiative.

b) Any perpetrator of violent crime (GBH) should, as a matter of course, be subject to targeted bail checks in order to reduce or minimise the risk to the victim(s). This should be based on the potential risks presented to the victim and witnesses. Information sharing with agencies is critical to ensuring effective and timely verification checks are made.
Recommendation 3:
SDP to ask all agencies to review how they share information in relation to excessive use of alcohol where cases indicate this is appropriate to prevent or reduce both violent crime and offences of Domestic Abuse happening in the future.

Alcohol was a feature in the murder with the offender having been drinking before committing the offence. There is good evidence from recent DHR's within County Durham that alcohol has been a major contributing feature within them.

Domestic Homicide Review Action Plan

RECOMMENDATIONS	DESIRED OUTCOME / LESSONS LEARNED	ACTIONS	TIMESCALE	LEAD AGENCY	PROGRESS
1) That Durham Constabulary considers the opportunity to lead a partnership approach to a 'weapons amnesty' in order to reduce the number of illegally held weapons in particular firearms.	This case can be used to 'market' the approach to the community. Such amnesties are known to be successful in the anonymous surrender of a range of weapons which could otherwise come into the possession of individuals.	Durham Constabulary to coordinate a countywide 'weapons amnesty' under the banner of the Safe Durham Partnership.	September2014	Paul Goundry, Durham Constabulary	Durham Constabulary held a weapons amnesty between 8-16th November 2014.
2a) The SDP asks Durham Constabulary to consider where individuals are subject to bail for crimes of violence (GBH) Officers In Charge of an investigation proactively consider and document rationale for their decision that a formal letter is handed to the suspect/defendant. 2b) Any perpetrator of violent crime (GBH) should, as a matter of course, be	An endorsed letter by the Police/Courts /Probation and other relevant agencies working in partnership, notifying the individual of the steps that will be taken in the event of information or indication that the subject is in breach of any of the specified conditions. Although warnings are given verbally at the time of bail, the consequences	Durham Constabulary to coordinate a task and finish group to review and improve procedures and scope the feasibility of the development of an endorsed letter. Task and finish group to review relevant information sharing procedure to ensure checks are made. Task and finish group to coordinate awareness raising activity across the relevant	December 2014	Paul Goundry, Durham Constabulary	Both actions complete.

subject to targeted bail checks in order to reduce or minimise the risk to the victim(s). This should be based on the potential risks presented to the victim and witnesses. Information sharing with agencies is critical to ensuring effective and timely verification checks are made.	of breaches should be more overtly addressed by a partnership approach as a way of reducing and making efforts to re-enforce that any grant of bail with conditions is not a step that is taken lightly by the judicial process. There will need to be an awareness programme to implement this initiative.	agencies on implementation of initiative.			
3) Agencies to review how they implement Identification and Brief Advice (IBA) for alcohol, drugs and mental health issues to prevent or reduce both violent crime and offences of domestic abuse happening in the future.	Alcohol was a feature in the murder with the offender having been drinking before committing the offence. There is good evidence from recent DHR's within County Durham that alcohol has been a major contributing feature within them.	Discussions will take place with the Chief Constable about implementing IBA in Durham Constabulary. Sections within the police will be prioritised for training and then trained in IBA.	December 2014	Lynn Wilson, Public Health	This action is ongoing.