Blackburn with Darwen
Community Safety Partnership

Domestic Homicide Review
Ref: BwD DHR 02/2013

<u>Overview Report</u>

Report into the death of Adult Y

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1. INTRODUCTION

This report of a Domestic Homicide Review examines agency responses and support given to Adult Y, a resident of Blackburn with Darwen, prior to the point of his death on 31st March 2013.

The review has considered agencies contact/involvement with Adult Y and the perpetrator, Adult Z, from 1st April 2011, until the present day.

The key purpose for undertaking the Domestic Homicide Review was to enable identification of lessons to be learned from this homicide, in order that professionals are able to understand fully what happened in this case and, most importantly, what, if anything, can/needs to be changed to reduce the risk of such a tragedy happening again.

1.1 **The circumstances giving rise to this review are as follows**;

The victim, Adult Y, was the father of the perpetrator, Adult Z. The two men had been estranged for a number of years but had recently renewed contact and Adult Z had moved from West Yorkshire to live with the victim seven days prior to Adult Y's tragic death. In the early hours of Saturday 31st March, 2013, the emergency services were called to Adult Y's home address to a report that he was being attacked by Adult Z. Upon arriving at the scene, the police discovered the body of Adult Y lying in the street outside his home address. Life was pronounced extinct by paramedics. Adult Z was arrested a short time later after surrendering himself to the police. The incident was witnessed by Adult A, daughter of Adult Y and step-sister of Adult Z.

The witness, Adult A, was subsequently interviewed by the police. During the interview she described Adult Y returning home from a night out. She and Adult Z were at the house awaiting his arrival. There had been no indication of any mal intent on behalf of Adult Z at that time. Almost as soon as Adult Y entered the room some words were exchanged between the two men, and without warning Adult Z attacked Adult Y, punching him several times to the face and body. Adult A ran from the house and rang 999 for the emergency services. She then saw Adult Z physically drag the victim from the house into the street and resume attacking his prostrate body by delivering kicks and stamps, mainly to the head. The perpetrator walked away from the scene on two occasions but returned and delivered further blows. He finally walked away prior to the arrival of the police and paramedics.

On 31st March, 2013, a post–mortem examination of Adult A was performed by a Consultant Forensic Pathologist. The examination found that Adult Y had sustained extensive, multiple, head and brain injuries. The pathologist found very few injuries to any other part of the body other than a small number of bruises on his arms which may have been defensive injuries. He had also suffered bruising to his armpit which may have been caused when he was dragged from his house into the street. The examination also confirmed the

presence of cancerous tissue in his bowel, liver and lungs, though this had not contributed to his death. The pathologist described Adult Y as being moderately intoxicated at the time of death, a blood alcohol level of 226mgs was recorded. Again this was not believed to have been a contributory factor to his death. The pathologist concluded that Adult Y's death was due to the extensive head and brain injuries, these injuries having been consistent with a violent assault comprising punches, kicks and stamping. Although the examination was unable to accurately state the number of such blows that were delivered, from the number of injury sites that were identified the pathologist was able to say that there "must have been many more than 19 impacts". The findings were consistent with Adult A's version of events.

Adult Z appeared before Preston Crown Court on 30th September 2013, he entered a plea of guilty to the charge of the murder of Adult Y. He was sentenced to life imprisonment with a minimum term tariff of 18 years and 8 months. In sentencing the following aggravating factors in the case were taken into account;

- The vulnerability of the deceased.
- The hatred demonstrated by the perpetrator
- The brutality of the attack
- That the attack was witnessed by Adult Z's half-sister
- Adult Z's previous offending history.

Mitigation was considered with regards to his guilty plea.

1.2 **Purpose of the Review**:

Domestic Homicide Reviews were established on a statutory basis under Section 9 of the Domestic Violence, Crime and Victims Act, 2004, the provisions of which came into force in April 2011. The act requires that a review is undertaken in respect of the death of a person over the age of 16 years or over which has, or appears to have, resulted from violence, abuse or neglect by;

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

The purpose of conducting the review is to;

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

1.3 **Terms of Reference and Methodology**;

The Terms of Reference;

1. To establish the circumstances surrounding the homicide.

2. To establish whether there were any lessons to be learned from the case about the way in which professionals and organisations carried out their duties and responsibilities.

3. To identify clearly what those lessons are, how they will be acted upon and what is expected to change as a result.

4. To establish whether the concerns and responses by professionals and their organisations were appropriate both historically and in the time leading up to the homicide.

5. To establish whether organisations have appropriate policy and procedures to respond to the circumstances identified in this case and to recommend any changes as a result of the review process, with the aim of better safeguarding families.

6. All enquiries were restricted to the period of 2 years preceding the date of the homicide unless specifically requested under additional terms of reference provided to an individual agency.

Methodology;

The process began on 9th April 2013 when the requirement for the conduct of a Domestic Homicide Review and its terms of reference were agreed.

A bespoke Governance Panel was convened to oversee the process and an Independent Chair/Author was engaged (Para 1.6).

The relevant agencies were requested to provide chronological accounts of their contact with the victim, perpetrator and all members of their immediate family for a period of two years prior to the victim's death.

Where there was no involvement agencies replied accordingly. However those agencies continued to be considered during the review in terms of potential gaps in service and in relation to information exchange.

Each agency's report covered the following;

- Details of the victim, perpetrator and other members of the family household.
- Existing reviews involving the family.
- Services provided to the family.
- Details of contact with the family in the preceding two years.
- Chronology of dates of visits or contacts with the family in that time.
- Details of allegations, incidents or offences committed against the family and reported to the organisation.
- Details of criminal or civil investigations undertaken by the organisation in respect of the family.
- Details of requirements placed on the organisation to supervise any member of the family as part of a community or custodial sentence.

All fifteen of the agencies contacted responded. In total four agencies

responded as having had no contact with either the victim or suspect or with any member of the immediate family.

Eleven agencies responded with information indicating some level of involvement with the perpetrator, victim or both.

The review was unusually complex due to the cross-border involvement of agencies, in particular, the Police and Probation Services. To overcome potential issues representatives from the Governance panel met with the relevant managers of those agencies and invitations were extended to enable their attendance at Governance Panel meetings. To further simplify communications, members of the respective organisations in Lancashire agreed to become primary contacts.

1.4 **Contributors**;

Agencies participating in this review were:

- Lancashire Constabulary
- West Yorkshire Constabulary
- Blackburn with Darwen Local Authority
- Twin Valley Homes (Together Housing)
- NHS England – Lancashire Area Team
- Lancashire Care NHS Foundation Trust
- East Lancashire Hospitals NHS Trust
- Northwest Ambulance Service NHS Trust
- Lancashire Fire and Rescue
- Victim Support Cumbria & Lancashire
- Lancashire Probation Trust
- West Yorkshire Probation Trust
- Blackburn with Darwen Youth Offending Team
- Blackburn, Darwen & District Womens Aid
- East Lancashire Hospice

Individual management reviews (IMR) were initially commissioned from ten of those agencies. Following feedback from the Home Office Quality Assurance Panel, a request was made to the Lancashire Constabulary to complete an IMR of their involvement in the case.

Based on the absence of contact with either victim or perpetrator, the Panel did not commission IMR's from the following four agencies;

- Blackburn with Darwen Local Authority
- Lancashire Fire and Rescue
- Victim support Cumbria & Lancashire
- Blackburn with Darwen Youth Offending Team.

Each of the agencies conducting an IMR provided a chronology of their contact with the victim, perpetrator or both for a period of two years prior to the victim's death. Where older records contained information concerning Domestic Violence issues these were included within the chronology. The overview report contains a combined chronology of key events at paragraph 2.3.

At an early stage of the process contact was made, via the Police Liaison Officer, with Adult B, the eldest daughter of the victim. She agreed to participate in the review on behalf of the family. However, acting on Police advice, the Chair delayed his meeting with Adult B until the conclusion of the criminal proceedings. Meetings subsequently took place and detailed information regarding all those involved was provided.

Consideration was given to interviewing the perpetrator following his conviction. Adult Z had made a 'no comment' interview during the police investigation and had offered no mitigation of his actions to the court. However, he had been subsequently visited in prison by his sister. During this visit he showed no remorse for his actions and appeared to be boastful of the outcome. It was therefore decided that an interview with him would not be productive.

1.5 **Governance Panel**;

The membership of the Governance Panel was as follows;

Andrea Rigby, Domestic Abuse Lead, Blackburn with Darwen Local Authority.

Ian Bell, Head of Housing, Twin Valley Homes.

Dean Holden, Detective Chief Inspector, Lancashire Constabulary.

Janet Thomas, Assistant Chief Executive, Lancashire Probation Trust.

Paul Lee, Head of Safeguarding, Blackburn with Darwen Local Authority.

Vivienne Blackledge, Blackburn, Darwen and District Womens Aid.

Katherine Watson, Head of Commissioning, Strategic Health.

Linda Clegg, Safeguarding Lead, Blackburn with Darwen Local Authority.

Yvonne Jackson, Safeguarding Practitioner/Domestic Abuse Lead, Lancashire Care NHS Foundation Trust.

Kathryn Bonney, Safeguarding Adult Lead, East Lancashire Hospital Trust.

Susan Warburton, Assistant Director NHS England Area Team.

Bridgett Welch, Assistant Director of Nursing Safeguarding Adults, Lancashire Care Foundation Trust.

Ian Glover, Independent Chair/Author (Para. 1.6)

1.6 **About the author**;

The author served in excess of thirty years as a police officer with the Greater Manchester Police, retiring from a middle management position in 2010. During those years he gained experience in many aspects of police work and public service provision including;

- Complex criminal investigations
- Road Traffic, collision investigation and offence detection.
- Internal disciplinary investigations
- Multi agency working
- Preparation of complex files and reports.
- Management of personnel and resources/budgets.
- Performance Management
- Business Change Management

Since retirement he has been a registered self-employed consultant and has provided business support services to a number of private companies.

Independence.

The author has previously completed a Domestic Homicide Review on behalf of the Blackburn with Darwen Community Safety Partnership, however, prior to that review, and in the intervening period, the author has had no connection or involvement with any of the agencies concerned.
The author was engaged as Chair of this review following a formal tendering and selection process.

1.7 **Timescales**;

This review commenced on 9th April 2013 and was completed and forwarded to Home Office by 30th November 2013. In accordance with the provisions of the Domestic Violence, Crime and Victims Act, 2004, in order to facilitate the inclusion of the decision arising from the criminal proceedings, the Home Office agreed an extension to the statutory completion date.
The report was subsequently considered by the Home Office Quality Assurance (QA) Panel and, following feedback, the report has been revised in line with recommendations.

1.8 **Confidentiality**;

The findings of this review are restricted, information is available only to participating officers/professionals and their line managers.

1.9 **Dissemination**;

Kevin Ruth, Chair, Blackburn with Darwen C.S.P.

Andrea Rigby, Domestic Abuse lead.

Susan Clarke, Head of Safeguarding/Designated Nurse Child Protection

Ian Bell, Head of Housing Twin Valley Homes.

Dean Holden, Chief Inspector Eastern Division, Lancashire Constabulary.

Janet Thomas, Assistant Chief Executive, Lancashire Probation Trust.

Paul Lee, Head of Safeguarding, Blackburn with Darwen Local Authority

Karen Cassidy, DAAT

Vivien Blackledge, Blackburn, Darwen and District Womens Aid (BDDWA)

Katherine Watson, Head of Commissioning, Strategic Health.

Linda Clegg, Safeguarding lead Blackburn with Darwen Local Authority

Yvonne Jackson Safeguarding Practitioner/ Domestic Abuse Lead, Lancashire Care NHS Foundation Trust.

Kathryn Bonney, Safeguarding Adult Lead, East Lancashire Hospital Trust.

Susan Warburton, Assistant Director NHS England Area Team.

Bridgett Welch, Assistant Director of Nursing Safeguarding Adults, Lancashire Care Foundation Trust.

Vivienne Forster, Northwest Ambulance Service NHS Trust.

Gini Whitehead, Head of Service, West Yorkshire Probation Trust.

Kirklees DHR Group.

2. THE FACTS.

This section of the report examines the history of the both the victim and perpetrator, provides a chronology of the key events relevant to the review and summarises the findings of the Individual Management Reviews undertaken by the agencies concerned.

2.1 Background – Adult Y – the victim.

Adult Y was sixty years old at the time of his death. He had been a resident of Darwen, Lancashire, for the majority of his life. Adult Y fathered four children by different wives/partners. His first child, Adult B was born in 1972. His second child, the perpetrator was born in 1981. Two further children were born in 1985 (Adult A) and 1998.

For the majority of his working life, Adult Y was a self employed plumber/building contractor, retiring only when his health began to deteriorate.

He had a busy social life and had an interest in boats, particularly canal boats. Adult Y had two sisters and was especially close to one of them. Unfortunately circa 1999, she died as a result of a fall. It is believed that her death badly affected the victim and he became prone to periods of depression.

It was a feature of his social life that it was mainly based around licensed premises. Perhaps surprisingly he did not drink alcohol in the home. He was however a heavy drinker and this invariably led to domestic tension with the majority of his partners.

In the later years of his life he tended to move home on a frequent basis and spent sometime in the Southport, Wigan and Ormskirk areas. It would appear that he never settled down and after returning to Darwen he stayed at the home of his cousin before eventually finding himself having to stay at the Salvation army hostel in Blackburn.

Following his cancer diagnosis, Adult Y was supported by the statutory agencies and was housed in the Darwen area where he then lived alone.

Adult Y had little or no contact with two of his children but had sporadic contact with the others and his closest relationship was with his eldest daughter (Adult B). She was supportive of him upon his return to Darwen and throughout the period of his illness. Although he was, in the main, an absent parent, Adult B found him to be gentle and caring towards her, their relationship improving during this period. Adult B had confided in her and, following his terminal diagnosis, had expressed the wish to be reunited with his children before he died.

2.2 **Background – Adult Z – the perpetrator**.

Adult Z was under three years of age when his mother and father (Adult Y) separated upon the breakdown of their marriage. He remained with his mother and they moved to the West Yorkshire area. His mother subsequently remarried and Adult Z was raised in a stable and loving family environment.

At the age of 18 Adult Z was made aware by his mother that, during their marriage, she had been a victim of domestic abuse inflicted by Adult Y. The information apparently caused Adult Z to resent his father.

Upon leaving school Adult Z initially joined the army but was unable to adapt to service life and he left after three months. He subsequently gained an NVQ in joinery, qualifying at the age of 23. His employment record is punctuated by gaps due to imprisonment and other factors. At the time of the homicide he was unemployed, apparently due to the previous court proceedings. He had however registered at the job centre in Blackburn.

Adult Z first came to the notice of the police in 2000, West Yorkshire Police have sixteen custody records in respect of him, the last being in November 2012. The majority of allegations made against Adult Z concerned acts of violence against persons and property, alcohol misuse was a common factor.

In 2005 Adult Z was arrested and subsequently sentenced to a term of imprisonment for s18 Offences Against the Person Act 1861 (wounding with intent), the case involved him stabbing a neighbour with a knife.

In 2009 he came to the notice of the police for a domestic related assault. This was the first time that he had been connected with this type of offence. Over the subsequent years he has been similarly accused of domestic related offences against a number of different partners.

In November 2011, following another allegation of assaulting his partner in their home, he was arrested and charged with the offence of common assault. The case was heard at Kirklees Domestic Violence Court in February 2013, Adult Z pleaded guilty and the case was adjourned for preparation of pre-sentence reports.

The case was finalised on 21st March 2013 when Adult Z was sentenced to 20 weeks imprisonment suspended for twelve months. A supervision order was imposed as was a restraining order intended to protect the victim.

As a result of this case Adult Z was effectively homeless. Following the case he stayed, on a temporary basis, with a former girlfriend (F3). On the 23rd March 2013, West Yorkshire Police received a complaint from F3 that she had been assaulted by Adult Z. Officers attended at the address. Adult Z had left prior to their arrival and consequently F3 decided not to proceed with the complaint of assault against him. She did not reveal to the officers that the two of them had previously been in an intimate relationship. The officers made a search for Adult Z but were unable to locate him.

Adult Z returned to the address later in the night and was admitted by F3. She subsequently gave him some money the following morning to enable him to travel to Adult Y's house in Darwen.

Following his arrival in the Blackburn with Darwen Local Authority area, Adult Z registered for employment with the local Job Centre.

2.3 **Background circumstances to the case**.

This section documents the relationship between Adults Y and Z and the existing circumstances leading up to the death of Adult Y. The majority of the information was obtained from family members during the Police Investigation.

Adult Y was not in contact with his son for many years, though, following a family dispute, Adult Z did go to stay with him for a short period of time around the year 2000.

In 2008 Adult Z made contact with Adult B via a social networking site and they exchanged messages, during that time he also made similar contact with Adult

A. It was during this time that Adult B learned that Adult Z had a 'love/hate relationship with Adult Y though it is not clear if the two men had been in regular contact.

Adult B had had very little contact with Adult Y for a number of years though she became increasingly involved in his care following his cancer diagnosis.

Upon learning of his father's condition, Adult Z apparently became very concerned for him and, following his discharge from hospital, the two of them started to have regular telephone conversations.

During this period Adult B spoke with Adult Z via telephone and asked him if he intended to visit Adult Y. He replied that he didn't know what he would do if he came over and saw his dad, or would end up doing! Adult B interpreted this as almost a physical threat, though at that time she did not pursue the matter further.

In the middle of March 2013, Adult B unexpectedly received a call from Adult Z requesting her to lend him some money though he didn't state what he required it for. She refused, however she visited Adult Y on his birthday, whereupon he told her that he had sent £30 to Adult Z and that he had then been asked for a further £7 as Adult Z's account was 'in the red'.

Adult Z's lack of money would become a repeated issue in the subsequent days following him moving in with his father.

Upon learning of Adult Z's situation following his conviction, Adult Y told Adult B that he feared that Adult Z was homeless. He told her that Adult Z couldn't live with him though he would accompany him to the Salvation Army to seek their assistance.

On 23/3/13 Adult B received a message from Adult A advising her that Adult Z had indeed moved in with Adult Y.

On 28/3/13 Adult B received a text message from Adult Z stating "Fuck me, I've only been here since Saturday and he's already doing my head in, he can't prioritise anything for the life in him. I've sorted the job centre out and some other things for myself. Anyways he said to me the other night that he's a lunatic. To be honest he scares me."

The following day Adult B received a further text message from Adult Z which said Adult Y had returned home the previous night in a poor state and that he was 'pissed off' with him. He also requested her to let him have the telephone number for Adult Y's carers.

With hindsight, these and other text messages reveal a rising anxiety and frustration on behalf of Adult Z towards Adult Y. Other messages made reference to Adult Y's savings and his legacy.

Adult B contacted Adult A via text message and advised her of her concern that the two men were likely to 'beat each other up' and she suggested that Adult Z may have a personality disorder.

During this period of time Adult B recalls having a conversation with Adult Z in

which he told her of his anger that Adult Y wouldn't loan him the money for a haircut despite the fact that he had learned that Adult Y had £5000 in the bank. Adult B recalled that during this conversation Adult Z had seemed very confused and agitated, unable to remain focussed on one topic before moving onto another.

On 30/3/14 Adult Y accompanied a female friend to Bolton where they visited a number of public houses before returning to the Darwen area where they then went to the ICI private members club for the evening. During the time they spent together, Adult Y informed the friend that Adult Z was constantly asking him for money.

That same day Adult A met Adult Z for the first time and they arranged to go to the ICI club to see their father.

Upon their arrival at the club, Adults A and Z joined Adult Y and his friend at their table where the conversation was convivial.

Adult Y bought drinks for the group, Adults A and Z later left the club prior to Adult Y and made their way to Adult Y's home.

Adult Y subsequently shared a taxi with his friend, dropping her at her home before continuing to his home address.

Upon entering his house a short conversation took place between Adults Y and Z, though what was said is unknown, Adult Z then leapt up from his seat and, without warning, attacked Adult Y punching him to the face and body. Adult A ran from the property and telephoned the emergency services, whilst doing so she saw Adult Z drag Adult Y into the street and continue his assault, kicking and stamping on him, predominantly to his head.

2.4 Chronology

Date	**Agency providing information.**	**Event/Actions/Outcomes**
Circa 1984	Lancashire Constabulary (Investigation documents)	Adult Y separates from Adult Z's mother, she eventually resettles in West Yorkshire and re-marries. Adult Z raised in stable family environment. Victim has no contact with the Adult Z for many years thereafter.
10/04/2009	West Yorkshire Police	F1 and Adult Z are partners. They had been out the previous evening for a few drinks and returned home in the early hours and carried on drinking. A verbal argument ensued and Adult Z left and returned to his home address and was followed by F1. Once at Adult Z's home address another argument ensued and Adult Z grabbed F1 and threw her to the floor on two separate occasions. Both parties then returned to her home address. At the F1's home address there were two further witnesses and another verbal argument ensued. Adult Z assaulted one of the witnesses, F2, in the lounge. Second witness called Police. On arrival, circumstances were relayed

		to the Officer and Adult Z was arrested. No visible injuries to either complainant. Victim F1 was reluctant to report the incident and there was no previous domestic history between the couple. F1 initially made a statement of complaint then a further CD to P (Complainant Declines to Prosecute) statement. Incident assessed as standard risk Adult Z was arrested and interviewed, matter referred to CPS who advise NFA due to inconsistent reports from the victims. Domestic interventions offered and all declined by F1 Child C1 present, not a witness in the house – Domestic Violence notification made to Social Care.
02/07/2010	West Yorkshire Police	Report of arson at address of F4 an ex-partner of Adult Z. A pig's head was also discovered in the living room. Adult Z was arrested on 14/09/2010 and interviewed.
18/07/2010	West Yorkshire Police	F4 and Adult Z are partners. An argument ensued between both parties and Adult Z punched the victim in the face causing swelling and bruising. Adult Z damaged a number of items in the victim's bedroom. Adult Z was arrested and interviewed. F4 and Adult Z did not live together. Adult Z stated it was he that was assaulted and that the victim caused the damage. Suspect bailed 37(3) until 31/08/2010 for further enquiries and CPS advice. Victim updated by Safeguarding Unit, incident assessed as standard risk. CPS advise NFA Victim and suspect updated. DV interventions offered but declined by F4.
17/08/2010	West Yorkshire Police	F4 attended Adult Z's address with some property to return to him. Adult Z kicked offside door of F4's vehicle which hit F4. Adult Z was arrested and charged with common assault and damage offences.
14/09/2010	West Yorkshire Police	Adult Z arrested on suspicion of arson to unoccupied dwelling (address of former partner F4 which occurred 02/06/2010). Charged with criminal damage and bailed with conditions to appear at Batley and Dewsbury Magistrates Court on

		27/10/2010.
21/10/2010	West Yorkshire Police	Further domestic incident involving F4. Adult Z attended the property and walked in, F4 asked him to leave and he refused. After an hour he left and she called police. Adult Z seen by police and was chased whereby he grabs Police Officer by the throat and punched and kneed the Police Officer causing injuries (initially believed to be broken leg but was confirmed to be sprained right knee and ligament damage). Adult Z detained by CS spray and handcuffs and arrested. Adult Z remanded on conditional bail to Dewsbury Magistrates Court on 01/11/2010 for criminal damage, obstruct PC and section 47 assault, with conditions of residence and not to approach the victim F4. Support to victim provided by the Safeguarding Unit.
25/10/2010	West Yorkshire Police	Adult Z appeared at Batley and Dewsbury Magistrates Court and found guilty of criminal damage but not guilty of battery. Sentence postponed until 01/11/2010.
27/10/2010	West Yorkshire Police	Adult Z appeared at Batley and Dewsbury Magistrates Court, found guilty of disorderly behaviour/threatening/abusive/insulting words likely to cause harassment alarm or distress. Sentence postponed until 01/11/2010 No pleas taken for the criminal damage regarding the arson reported on 02/07/2010. The case was withdrawn.
01/11/2010	West Yorkshire Police	Adult Z received a conditional discharge for 12 months.
12/02/2011	West Yorkshire Police	Adult Z was assaulted whilst in a public house. Adult Z was allegedly assaulted after being confronted about his domestic abuse history towards the niece of one of the suspects. Crime recorded and investigated. Summons issued for suspects for S39 assault and S4 POA.
25/02/2011	West Yorkshire Police	Adult Z appeared at Leeds Crown Court, found guilty of common assault (relating to Police Officer on 21/10/2010). Sentenced to 3 months imprisonment suspended for 12 months, unpaid work requirement for 100 hours, curfew requirement for 3 months with electronic tagging.
21/01/12	Twin Valley Homes	Adult Y applied to Twin Valley Homes for re-housing. His application stated no fixed address and his current situation in relation to his housing need was listed as "relationship

		breakdown and medical reasons" He also stated he was homeless and desperate to be re-housed
5/04/12	Twin Valley Homes	Adult Y Awarded highest medical priority by Blackburn with Darwen Council's homelessness service
19/06/12	East Lancashire Hospitals NHS Trust	Adult Y Elective Surgery admission to Ward C18, Royal Blackburn Hospital Bowel resection under general anaesthetic. Resulted in a stoma. Eldest daughter noted as NOK She accompanied Adult Y Admitted to Critical Care Unit, Royal Blackburn Hospital, and transferred to Ward C18 once stabilised. 28/6/12 Referral to Social Services for extra care on discharge. Awaiting keys to a new property, but still homeless Daughter concerned regarding safe discharge of her dad. Worked to ensure property was furnished and ready for habitation. Liaised with the OT staff. Results from investigations concluded carcinoma diagnosis. BH informed of this, and supported accordingly. 06/07/12 Meeting with ward staff nurse, Adult Y, his eldest daughter and Social Worker, re discharge. Assessed by Social Worker as having no care package needs. New property not ready until Saturday as unfurnished, but Adult Y adamant that he was going home on Friday. Noted Adult Y has been verbally aggressive towards his daughter, who was then no longer wanted any involvement with Adult Y or his discharge planning. Adult Y became verbally abusive about his daughter and also towards staff.
25/06/12	Twin Valley Homes	Adult Y Tenancy commenced
20/10/2012	West Yorkshire Police	F5 and Adult Z were in a relationship after previously being separated. Both parties were in drink when a verbal argument ensued over trust issues between both parties which had built up over the last few years. F5 had gone to her parent's house whilst the argument cooled down. F5 rang Police prior to leaving address and then rang back and stated not required. F5 seen by Police. Signed the Officer's PNB stating no further Police action required in response to this incident.

		Standard risk assessment made. Social Care notifications completed in relation to the children of F5. Letter sent to F5.
24/11/2012	West Yorkshire Police	F5 and Adult Z were ex-partners. They had been out in the town centre. Adult Z assaulted F5 by pushing and pulling her hair. They were separated by a witness, F6. Adult Z left and returned home. A short time later F5 and F6 returned home. A verbal argument occurred due to F5 wanting Adult Z to leave. During the altercation, Adult Z pushed F6, grabbed F5's throat, punched her and grabbed her hair. He dragged her downstairs punched her into a mirror, causing it to smash. Adult Z then punched the witness F6. Suspect interviewed but denied assaulting the victim. Adult Z charged with section 39 assault X 2 and conditionally bailed to Kirklees Domestic Violence Court to appear on 06/12/2012. Domestic Violence notifications made to Social Care concerning C2 and C3, children who resided at the address. F7 (babysitter) also present at the time. Victim supported by the Safeguarding Unit.
03/12/2012	West Yorkshire Police	Referral to the Safeguarding Unit from Social Care informing the Police they were conducting a S47 assessment on Adult Z's family due to domestic violence notifications and concerns.
27/01/2013	West Yorkshire Police	F8 rang Police and stated that she had let Adult Z, whom she had known for a few months stay a couple of nights at her address. She had caught him smoking weed and because she had a baby in the house she had asked him to leave. Adult Z had left and when F8 had asked for the house key back, he stated he had left it in the bedroom. F8 could not find the key and stated that Adult Z had the key in his pocket. F8 described Adult Z as a sneak, liar and that she didn't know what he was capable of. F8 stated that she felt unsafe going to sleep knowing that Adult Z could let himself in the house. F8 requested that Police ring Adult Z and requested the key to be returned. Police rang Adult Z who admitted that he still had the key so that he could retrieve his property from the address. He was advised that the Police would attend when he collected his property to prevent BOP occurring. A time of 2200 hours was agreed when a Police Officer and PCSO would meet Adult Z to allow him to collect his property. Adult Z attended and handed key to Police Officer. It was further arranged that Police and Adult Z would meet again the next day and 1800 hours so that Adult Z could collect the

		reminder of his property.
18/02/13	Twin Valley Homes	NHO visited Adult Y at his request to discuss a possible transfer to another ground floor flat with a walk in shower as the Council's Independent Living Service had refused – as per their policy – to adapt *Address.* NHO completed a transfer application form whilst at the property.
25/02/13	Twin Valley Homes	Authorisation was given by NHO's Line Manager for priority move to *address*, Darwen aground floor flat with ramped access and a walk in shower
26/02/2013	West Yorkshire Police	Adult Z appears Kirklees Magistrates Court and found guilty for section 39 assault. Remanded on conditional bail for sentence to 21/03/2013.
26/02/2013	West Yorkshire Probation Trust	Adult Z convicted of Section 39 Common Assault x 2 against his partner and her friend. Case adjourned until the 21.03.2013 for preparation of a pre-sentence report
7/3/2013	West Yorkshire Probation Trust	Adult Z attended appointment for preparation of report.
19/03/2013	West Yorkshire Police	F5 reported that Adult Z had posted threatening messages on his facebook page which referred to her. The messages did not state F5 by name but F5 stated that what was posted can only mean her. F5 stated that Adult Z was due in court in two days for assaulting her and her friend. The messages were assessed as not threatening or dangerous by the Police. F5 had been told by a friend about the messages because she had put a block on her own face book account. She was advised by the Police to request that her friends no longer read any messages from Adult Z's face book account to her. The advice given was appropriate in these circumstances.
21/03/2013	West Yorkshire Police	Adult Z appeared in Court relating to the assault on F5 and F6. He was sentenced to 20 weeks imprisonment suspended for 12 months, with supervision requirement, victim surcharge £80, compensation £100, £400 costs and subject to restraining order.
21/3/2013	West Yorkshire Probation Trust	Offender (Adult Z) appeared at Court for sentencing. Was sentenced to a Suspended Sentence order with a supervision requirement and a medium level activity requirement for 30 days. Was given an appointment to attend at Probation for the 27.3.2013
23/03/2013	West Yorkshire Police	F3 rang Police and reported that Adult Z had assaulted her when she had asked him to leave her home. F3 stated that Adult Z had been staying at her home whilst he had been attending Court. He had been drinking all day and had thrown

		her to the floor and put his hands around her neck. Adult Z had left the address and walked off to an unknown location. Police attended the incident and conducted enquiries with F3 in respect of the allegation of assault. F3 denied she had been assaulted and this was confirmed by a second witness at the address. F3 was advised to contact Police should Adult Z return to the address. Area search made for Adult Z to negative gain.
25/3/2013	West Yorkshire Probation Trust	Telephone call received from offender (Adult Z), taken by the Duty Officer. Explained that he had moved to Blackburn to help care for his father. The Duty officer explained that he would still need to report to West Yorkshire before his case could be transferred. Offender later called back to explain that he would be unable to report as he had no money and it was a 50mile round trip. Provided his new address in Blackburn
25/03/13	Twin Valley Homes	NHO visited Adult Y to complete tenancy sign up for *address*. Adult Y's son Adult Z was present and Adult Y explained that his son was helping him pack for the move to *address*. Adult Z left the room when the NHO entered.
26/3/2013	West Yorkshire Probation Trust	Telephone call from offender (Adult Z) to Duty Officer stating again that he was living in new area and wanted his order transferring. Duty Officer again reinforced that he needed to report in the first instance to West Yorkshire.
26/3/2013	West Yorkshire Probation Trust	Case was discussed with Senior Probation Officer to confirm stance that he (Adult Z) needed to report to West Yorkshire. Duty Officer then contacted offender to reinforce need to attend.
27/3/2013	West Yorkshire Probation Trust	Offender (Adult Z) attended as instructed and full induction undertaken. Offender confirmed his intention to reside in Blackburn. Father's consent given over the phone. Agreed that reporting instructions would be secured for Blackburn.
27/3/2013	West Yorkshire Probation Trust	Offender Manager e-mailed Lancashire Probation Trust requesting formal transfer. E-mail contained relevant information regarding offence, risks, sentence
27/03/2013	Lancashire Probation Trust	LPT receives an initial email enquiry from the perpetrator's Offender Manager regarding potential transfer of the case from WYPT to Lancashire.
28/3/2013	West Yorkshire Probation Trust	E-mail received back from Lancashire Probation Trust providing reporting instructions for Offender in Blackburn on

		the 4.4.2013 and confirmation that they would accept formal transfer once all relevant paperwork had been completed and sent through, in line with formalised transfer process.
28/3/2013	West Yorkshire Probation Trust	Offender Manager rang offender (Adult Z) and gave reporting instructions in Blackburn. Offender Manager also confirmed reporting instructions in writing to offender at new address provided.
31/3/2013	Northwest Ambulance Service	At 03:11 a 999 call was made to one of the Emergency Operations Centres (EOC) in North West Ambulance Service (NWAS). The caller identified as Adult A was very distressed and crying. She said her dad was dying and that he had cancer. Adult A said her brother had 'beaten her dad up'. She was outside and her brother and father were inside the property. Initially she said her father wasn't awake, he was breathing, there was lots of bleeding and he was 60 years old. Adult A described the family as 'mixed up' and said this was the first time she had met her brother and father. She was distressed and said she couldn't go back in the property as her brother was still in there. During the course of the 999 call she started screaming as her brother dragged her father outside of the house. She thought he was dead and said this many times though the Emergency Medical Dispatcher (EMD) did encourage her to calm down and check breathing. She did think her father was breathing a couple of times but it is hard to verify how effective his breathing was. RG was being encouraged to look at her father to assess whether he was breathing – to look in his mouth for obstruction. It became apparent she couldn't bear to look at him- she said he was such a mess 'there was blood everywhere'. The EMD stayed on the line to keep her calm until the police arrived then spoke with the Police officer. While the call was in progress the Dispatcher looks for the nearest available resource to send to the incident. A Rapid Response Vehicle) was initially allocated but stood down when an Ambulance became available and was closer (A186). The incident is coded as a Red1 which has a government target response time of within eight minutes. At 03:13 a double crew ambulance was dispatched. The crew were a Paramedic and Emergency Medical Technician 2 (EMT2). During the course of the call the Ambulance crew is told to

		'stand-off' by the EMD at 03:16 which essentially means not to approach the scene because it isn't safe. This was due to information passed by RG to the EMD that the attacker Adult Z was still at the scene. This is standard practice and maintains scene safety for the crew. The EMD places a warning on the system which alerts the managers the police need to be called to this incident. At 03:18 a call is placed to the Police by an EOC Manager to inform them of the incident (log 154). At the same time (03:18)he crew arrive near the scene but do not approach. The EMD stayed on the line during the call with RG until the Police arrived (Collar 3034) at 03:33. Message was relayed to the crew that they can approach the scene at 03:34 however the Police on scene had already approached the crew directly The Paramedic described the patient as "lying on the floor facing him" as he approached the flats. There was a lot of bleeding (blood in patient's mouth) and pupils were fixed and dilated. It was obvious to the Paramedic the patient had massive head trauma and bleeding head wounds. There was what looked like 'brain matter' on the floor by the patient. The Paramedic completed and documented his observations on the Patient Report Form.. At this point a Diagnosis of Death Form was completed as the criteria were met from the observations taken showing injuries incompatible with life. These observations were:- No respirations No pulse No recordable blood pressure. Glasgow Coma Scale was 1/1/and1 (1x3) score=3. This is the lowest score possible. A well person would score 5x3=15. Pupils fixed and dilated. Electrocardiogram performed (4 lead) - showed asystole- no electrical activity/ no heartbeat. Signs incompatible with life The patient (Adult Y) was not conveyed to hospital. The Police secured the scene and the body of the patient was left

		with the Police and Senior Investigating Officer. The attending crew became clear from the incident at 04:45 and thereafter made statements to the Police at Blackburn Police Station.
31/3/2013	Lancashire Constabulary	At 3.18am on Sunday 31st March 2013 Lancashire Police received a telephone call from North West Ambulance Service who were attending a call to an address in Darwen following the report of an attack on a male. Police Officers attended at the address where they liaised with paramedics and discovered the lifeless body of Adult Y on the footpath outside the house. It appeared that Adult Y had sustained a serious head injury, and was bleeding badly. Paramedics pronounced Adult Y dead at the scene. 03.49 hours Adult Z telephones Police control stating his intention to hand himself in at Blackburn police station but does not know the way. Operator advises Adult Z to return to the scene and wait outside property. 04.06 Adult Z arrested and conveyed to Blackburn police station. Post Mortem Examination carried out at the mortuary, Royal Blackburn Hospital by Forensic Pathologist Naomi Carter, BSc (Hons), MB ChB, FRCPath, DipRCPath (Forensic). The cause of death was recorded as head injury consistent with repeated heavy blows to the head, compatible with punches, kicks and stamps.
1/4/2013	Lancashire Constabulary	Adult Z charged with the murder of Adult Y remanded to Blackburn Magistrates Court on 2/4/2013
2/4/2013	West Yorkshire Probation Trust	Telephone call from staff in Lancashire advising that offender (Adult Z) arrested and charged for alleged murder of father.
04/04/2013	Lancashire Probation Trust	An appointment was made for the perpetrator to report to the duty officer at Blackburn Probation Office at 4.15pm on that day.
24/6/2013	Lancashire Constabulary	PCMH hearing Preston Crown Court, trial date set for 30/9/2013
30/9/2013	Lancashire Constabulary	Adult Z enters guilty plea and is sentenced to life imprisonment with a minimum tariff of 18years 8 months.

2.4 **Family Table**;

Adult Y – victim – born 1953
Adult B – Eldest child of Adult Y – born 1972
Adult Z – Perpetrator – only son of Adult Y – born 1981
Adult A – Daughter of Adult Y – born 1985
PH – youngest child of Adult Y – born 1998

(estranged).

2.5 **Summary of Individual Management Reviews**.

2.5.1 **West Yorkshire Police**.

The West Yorkshire Constabulary (WYP) review catalogues their contact with Adult Z both as a victim and perpetrator dating back to 2000. Adult Z had several convictions for violence including assaulting police officers.

WYP records indicate that Adult Z first came to notice for domestic related assaults in 2009. Between 2009 and the time of his arrest Adult Z had a number of intimate relationships with female partners.

Three of those relationships had resulted in a number allegations of domestic abuse made to the police naming Adult Z as the perpetrator.

A common theme in those allegations was Adult Z's consumption of alcohol, though there is nothing to suggest that his consumption was excessive.

Despite the number of allegations, Adult Z was only actually charged with domestic related offences on four occasions and of these he was acquitted on one occasion.

The remaining three instances dealt with by the courts resulted in sentences ranging from suspended prison sentences to conditional discharge.

Adult Z 's final conviction in West Yorkshire resulted from an incident in November 2012 when, upon returning home from an evening out with his partner and her friend, he assaulted both women, punching, and pulling the hair of his victims.

WYP had followed prescribed procedures on each of the domestic violence allegations, DASH risk assessments had been undertaken and on each occasion the result had been identified as standard risk. Their review concluded that, in respect of the latest incident, the assessment should have been rated as medium. However such an assessment would not have triggered the M.A.R.A.C. process which is restricted to high risk cases.

Adult Z appeared before the Kirklees Magistrates Court on 21st March 2013, having entered a guilty plea, he was sentenced to 20 weeks imprisonment suspended for 12 months with a supervision requirement and a restraining order attached.

Following his release from court Adult Z went to stay, temporarily, with F3.

On 23rd March 2013, WYP received a call from F3 alleging that she been assaulted by Adult Z.

The police attended the scene. Adult Z had left prior to their arrival. They were not made aware by F3 that she and Adult Z had historically been in an intimate relationship and she withdrew her allegation that Adult Z had assaulted her. The DASH process was not triggered, though the attending officers did make a concerted effort to find Adult Z.

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The DHR author requested the WYP to conduct a detailed review of the circumstances and their involvement in this particular event. Their review team interviewed both the officers involved and all records pertaining to the incident were examined.

Their review reveals that the result of Adult Z's court appearance on 21st March 2013 was not entered onto the courts' LIBRA' I.T. system until 27th March, thereby resulting in the relevant information being unavailable to police officers via the PNC.

The review concludes that, in the circumstances, all existing West Yorkshire Police policies and procedures were correctly applied.

The review makes no recommendations.

2.5.2 **West Yorkshire Probation Trust (WYPT)**

In light of the circumstances of this case and in accordance with existing policy, West Yorkshire Probation Trust undertook a Serious Further Offence Review. The relevant sections of that review were trans-posed into an IMR for the purposes of this review.

The review focuses specifically on their involvement with the offender Adult Z following his conviction for a domestic related assault on his then partner, the offence occurring in West Yorkshire in November 2012.

On 26.2.2012 at Kirklees Magistrates Court, Adult Z was convicted of an offence of Common Assault contrary to S39, Criminal Justice Act 1988. The case was adjourned to enable the Probation Service to prepare a pre-sentence report.

The report provides insight into Adult Z's propensity towards violence, particularly in the domestic environment. He had previous convictions dating back to 2003 and had previously served a custodial sentence for an offence of wounding (2005). That particular matter was not domestic related.

The report mentions the fact that the court case had resulted in Adult Z losing his home and notes that at the time of preparation he was in fact 'sofa surfing' (a term used to indicate that he was sleeping at acquaintances homes on a temporary basis). Adult Z does make mention of his intention to move to Blackburn during the interview.

The report rates Adult Z as a medium risk in terms of both causing harm and committing further offences.

The pre-sentence report makes a number of recommendations to the court with regards to suitable disposals.

The IMR details the effective manner in which the author of the pre-sentence report had undertaken their role. It documents good practice in terms of evidence gathering and appropriate risk assessments and recommendations. The review also finds that the subsequent management of Adult Z's case

through to transfer to the Lancashire Probation service was carried diligently and in accordance with policy.

The review makes no recommendations.

2.5.3 **Twin Valley Homes (TVH)**

The Twin Valley Homes review details their contact with Adult Y. The organisation had no contact with Adult Z whatsoever.

Adult Y first approached TVH in January 2012 applying for accommodation stating that he was homeless. TVH registered his application. Approximately two months later, following medical assessment he was awarded standard medical priority, as his health deteriorated the marker was upgraded to highest medical priority. He was subsequently housed on 26th June 2012.

The review catalogues the organisations contacts with Adult Y. There are no remarkable events recorded. Adult Y was subsequently offered a different address, one which was particularly suitable to his medical needs. He accepted the offer.

On 25th March 2013, an official from the company visited Adult Y with regards to the tenancy agreement for the new address. At the time of the visit they were introduced to Adult Z by Adult Y who explained that Adult Z was assisting him to pack for the move. Adult Z left the room when the official entered.

The review concludes that TVH would not do anything differently in dealing with an applicant in the same circumstances as Adult Y and therefore makes no recommendations.

2.5.4 **Lancashire Constabulary**

Lancashire constabulary had had no contact with Adult Z prior to the death of Adult Y.

Adult Y had first come to the notice of the Constabulary in 1974. He was known to them for offences of dishonesty and through his historic involvement in incidents of Domestic Abuse towards female partners over many years. A pattern of alcohol misuse was evident throughout.

In February, 2012, Adult Y was arrested by the police for providing a positive roadside breath test. He subsequently refused to provide an evidential sample of breath at the police station and was later convicted at the Magistrate Court and received a fine and disqualification from driving. During the course of the police involvement in the case, nothing was brought to their attention with regards to Adult Y being vulnerable or at risk from anyone.

At 3.18am on 31st March, 2013, Lancashire Police received a telephone call from the Northwest Ambulance Service informing them that an ambulance crew had been despatched to an address in Darwen to a report of an assault on a male. The police were advised that the ambulance crew were standing off from the scene pending police arrival.

Officers arrived at the scene where they were met by the very distressed Adult

A, who had witnessed the incident. She is described in the review as being very frightened and in fear for her own safety. Adult A directed officers to where the deceased was lying in the street. The officers were then joined by paramedics. It was evident that Adult Y had suffered extensive head injuries and he was pronounced dead at the scene.

Adult Y named her step brother, Adult Z, as the perpetrator and the police commenced a search of the area to locate him.

At 03.49 am Adult Z telephoned the police indicating his intention to hand himself in at the police station. The call- taker advised him to return to scene, however he was intercepted and was arrested.

The police investigation into the case established that Adult A had met Adult Z for the first time that evening. The two of them had joined their father, Adult Y, at a local social club and had spent some time there prior to returning to Adult Y's home address.

The investigation also established that at the time of his death, Adult Y was receiving treatment for a terminal illness. Lancashire Police had not received notification from any agency to indicate that Adult Y was a vulnerable adult. During the period subject of the review, Adult Y had not made any calls to Lancashire Police for any form of assistance or intervention. Subsequent to the driving conviction, the force had had no other contact with Adult Y prior to his death.

2.5.5 **Northwest Ambulance Service**

On 31st March 2013, the Northwest Ambulance Service received an emergency call from the witness Adult A to the scene of the assault on her father. The call was received at 03.11 hours and an ambulance was despatched at 03.13 hours.

The incident was coded as a Red 1 which has a government target response time of within eight minutes.

During the early stages of the call Adult A initially stated that her brother "had beaten her dad up" and that both men were still in the house, however during the call she then started screaming that her brother had dragged her father out of the house and she thought he was dead.

At 03.16 hours the ambulance controller told the attending paramedics to stand off from the scene pending the arrival of the police. This decision was based on information that the offender was still at the scene.

The attending ambulance crew arrive nearby to the scene at 03.18 hours but then stand off until the arrival of the police at 03.34 hours.

Adult A remained on the line to the ambulance controller and was asked to go and check whether Adult Y was breathing. She was also asked to check in his mouth for signs of obstruction but it became evident that she couldn't bear to look at him.

Throughout this period of time the controller maintains telephone contact with

Adult A to obtain as much information as possible.

Upon arrival at 03.34 hours at the scene the attending paramedics examined Adult Y and found signs incompatible with life.

2.5.6 **Lancashire Probation Trust (LPT)**

The Lancashire Probation Trust IMR is relatively short, commensurate with their limited involvement in the case.

The review makes no reference to any agency contact with the victim, Adult Y.

On 27/03/2013 LPT received an initial email enquiry from Adult Z's Offender Manager regarding potential transfer of his case from WYPT to Lancashire.

An appointment was then made for Adult Z to report to the duty officer at 4.15pm on 4/4/13 at Blackburn Probation Office.

2.5.7 **The East Lancashire Hospitals Trust (ELHT)**

The ELHT review reports that the trust had had no contact with Adult Z.

The review therefore only relates to the services provided to Adult Y prior to 31st March 2013.

The review catalogues the treatment provided to Adult Y from 14/3/2012 until the time of his death.

Adult Y had been diagnosed with terminal cancer and had received in-hospital treatment on four occasions during the period and was also receiving ongoing treatment as an out-patient.

During the periods of in-hospital treatment, the report notes that Adult Y was supported by his eldest daughter, Adult B, it also records an instance of Adult Y being verbally abusive towards both Adult B and the hospital staff. This instance was not reported to the police.

The review identifies good practice in multi-agency working particularly with regards to addressing Adult Y's homeless status during the early stages of his treatment.

The review correctly asserts that there are no lessons to be learned from this case.

The review makes no recommendations.

2.5.8 **Lancashire Care Foundation Trust (LCFT)**

The LCFT review reveals no contact with Adult Z and again focuses on the treatment and support services provided to the victim Adult Y.

The review provides some insight into the day to day interaction between Adult Y and the nursing staff. Interestingly, concerning this case, he had talked to them about certain family members but never mentioned to them that he had a

son.

The review states that there was nothing to indicate that Adult Y was vulnerable and needed safeguarding, he did not have reduced capacity nor did he demonstrate difficulty in making or understanding decisions about his treatment.

The review mentions that Community Nursing patient records are left in the patient's home until the conclusion of their treatment. This is to enable the nurses to update the records contemporaneously. However, on this occasion, due to Adult Y's home address being a crime scene, the agency were unable to retrieve their records for some time. When eventually the scene was released it was discovered that the family had destroyed the medical records.

The review makes three recommendations;

1. The Community Nursing Service review procedures in regard to bereavement visits/family contact to ensure support for families following any death not just those receiving end of life care.

2. Findings of the report are fed back into the Professional Nursing Forum and AHP forums to support learning across all the services and recognition of the good practices identified.

3. Reduce the incidence of loss / destruction of patient held records by reiterating verbally and in writing to each patient how patient held records are cared for and retained.

The agency has put an action plan in place to address the recommendations.

2.5.9 **NHS England – Lancashire Area Team (LAT)**

The LAT review makes reference to the records of General Practitioners treating Adult Y and, to a lesser extent, Adult Z from 2011 to the 31st March 2013.

The review notes that the absence of any interaction with GP's by either Adult Y or Adult Z which relate to this DHR.

The document catalogues Adult Y's interactions with his GP regarding various medical matters.

Adult Z is noted as having historic substance misuse issues but there was nothing contained in his records to suggest that he suffered from any behavioural or mental health issues.

The document makes reference to the chaotic lifestyle of both the individuals but found nothing in the records which cited difficulties between the two in any way.

There are no recommendations emanating from this IMR.

2.5.10 **Blackburn, Darwen & District Womens Aid (BDDWA)**

The BDDWA review makes reference to a number of telephone conversations regarding an allegation of domestic violence perpetrated by the victim Adult Y on his then partner DH. The incident was not relevant to this DHR but the IMR identified a number of shortcomings in the agency's original response.

The recent introduction of a case management system and the implementation of an IDVA (Independent Domestic Violence Advisor) service have addressed the issues raised.

There are no recommendations arising from this IMR.

2.5.11 **The East Lancashire Hospice**

The Hospice review, makes reference only to Adult Y as they had no contact with Adult Z or any other family members.

Adult Y first came to the notice of the Hospice on 17/9/12, following referral by the Community Staff Nurse.

On 3/10/12 the Clinical Nurses Specialist Team visited Adult Y at his home address to undertaken an assessment. The assessment noted that Adult Y lived alone but had organised himself and his flat and was able to get out by means of his motorised scooter. He was eating well and socialising with friends. He was however short of breath on exertion. The assessment makes no reference to any other vulnerability.

The assessment adds that Adult Y requested and was given advice on the application process for a 'McMillan' grant, he stated his intention to make changes to his bathroom to improve his situation.

Whilst the involvement of the hospice with Adult Y was not directly relevant to the background to this DHR, the conduct of an IMR nevertheless proved fruitful, as it identified a small number of procedural shortcomings which are now being addressed.

3 ANALYSIS

The following section analyses the actions and involvement of each individual agency in the case and also the content of their Individual Management Reviews.

3.1 West Yorkshire Police (WYP)

The West Yorkshire Constabulary review demonstrates that the organisation had, historically, by far the greatest contact with any of the persons involved in this case. Their contact entirely concerned Adult Z.

He had come to their notice for a variety of offences from an early age but his first involvement with an allegation of domestic violence occurred in 2009.

This case involved the allegations that Adult Z had assaulted his then partner and another person following an evening out. The case was referred to CPS direct for a charging decision, but the advice given was not to charge due to

discrepancies in the statements. West Yorkshire Police demonstrated a robust approach in this case by making further enquiries to overcome the issues raised. The case was overseen by an Inspector and was subsequently referred to the Local CPS for a charging decision. On this occasion the CPS advice was again not to prefer charges.

There is evidence that the WYP followed prescribed DASH processes and involved their Safeguarding unit in the case. The case was also notified to Social Care. The case was assessed as standard risk.

In July 2010 Adult Z was living with a new partner, F4, when following an argument, it is alleged that he assaulted her (punching her to the face) and also caused damage to her property. He was arrested and interviewed, he denied the offences and claimed to have been the victim of the assault. A file was submitted to the CPS but the advice was not to proceed due to lack of evidence.
Owing to the absence of children in this case the matter was not referred to Social care but the Safeguarding Unit offered support and intervention which was declined by the victim. The incident was rated as standard risk.

Less than one month later F4 and Adult Z were apparently separating. She went to his address to return some property. During this meeting Adult Z kicked the door of F4's car which struck and injured her. He was arrested and charged with an offence of common assault, but the case was later dismissed at the Magistrates Court. There is nothing with the WYP review to indicate that this incident was actually classified as being one of domestic violence and there is no evidence of further rating or interventions.

In September 2010, Adult Z was arrested in connection with an offence of arson which had occurred three months earlier at F4's home. On that occasion he was charged with causing criminal damage and was released on bail with conditions. Once again there is no information within the IMR to indicate that this incident was treated as one of domestic violence.
The matter was later heard before the Magistrates Court and Adult Z was convicted and received a conditional discharge for a lesser offence under the Harassment Act.

In October 2010, there was a further domestic violence incident involving Adult Z and F4. The circumstances were such that Adult Z was in breach of bail conditions which had been imposed on him for another matter. Upon arrest he became violent and attacked the arresting officer. He was subsequently charged and placed before the court. He was eventually convicted at Leeds Crown Court and was sentenced to three months imprisonment suspended for twelve months and made subject of electronic tagging. The IMR makes no reference to the matter being classified as a one of domestic violence and there is no indication of a risk assessment or rating process having taken place.

Adult Z next came to Police notice in October 2012. On that occasion he and his then partner F5 had been out drinking together, upon returning home an argument ensued and F5 felt it necessary to telephone the police, she then left the house and went to her parents house to 'let things cool down'. She subsequently recontacted the police to advise them that they were no longer required. In accordance with policy, the police did in fact attend and speak with F5 at her parents house. She signed an officer's notebook to indicate that she didn't want further action to be taken. On this occasion there were no children

present, however the officer did notify Social Care regarding F5's children. The incident was classed as standard risk.

In late November 2012, a further incident occurred involving Adult Z and F5. On that occasion they had been out drinking together and whilst out Adult Z assaulted F5 by pushing her and pulling her hair. A third party intervened and Adult Z left the scene and returned home. F5 later returned home with a friend. Upon her arrival the argument resumed and F5 asked Adult Z to leave the house. He then attacked her, grabbing her by the throat, he punched her, grabbed her by the hair and dragged her down a staircase before pushing her into a mirror, causing it to smash. During the melee he also physically pushed her friend and further assaulted her. The Police attended and Adult Z was arrested and subsequently charged with two offences of S39 assault. One charge each in relation to the two victims. He was then released on conditional bail to appear before the Magistrates Court.
As a result of this incident F5 received the support of the Safeguarding Unit and owing to the presence of children at the address, the case was referred to Social Care. They undertook an initial assessment on the family.
Once again the DASH risk assessment was finalised as standard risk and as a result the MARAC process was not invoked.
The WYP IMR makes the following observation regarding this assessment;

"*In hindsight, the more appropriate assessment of risk would have been medium, taking into account the previous offending and domestic violence history between Adult Z and his former partners. However the Safeguarding Unit did recognise his offending history and intervened with the necessary advice and support to F5. They made the appropriate liaison with Social Care, regarding the child protection concerns, applied for special measures for F5 at court, and supported her throughout the court process, including the obtaining of the restraining order. There was never an imminent threat of further violence towards F5; therefore it was appropriate that the case was not assessed as high risk. It is only the high risk cases of domestic violence that are considered for referral into the MARAC process.*"

The DHR author acknowledges the WYP review team's comments and notes their reference to previous offending and the domestic violence history between Adult Z and his former partners. However, the chronology suggests that earlier incidents were considered on an individual basis and no account was taken with regards to Adult Z's capability for extreme violence as demonstrated in the wounding matter for which he was convicted in 2005. In that case he had stabbed a neighbour.

The CAADA–DASH RIC allows for Professional Judgement as a referral criteria and, based on the information of the severed pig's head incident alone, the case could have been referred on. The criteria also allows for escalation of risk through an escalation in the number of incidents, again this could have been an opportunity to allow Adult Z to be risk managed in a multi agency arena setting and offer assistance to Adult Z to address his behaviour and assist his then current partner.

The author acknowledges that, nationally, procedural differences inevitably exist, and that examples of good practice will be manifold, but considers it useful to draw attention to the practice (outlined below) adopted in Lancashire, which may have resulted in a different approach to the management of Adult Z.

In Lancashire the medium DA referral would have prompted input from a specialist agency such as WA. Safety In Numbers research (Safety in Numbers, Howarth, Stimpson, Barran and Robinson 2009.)(Appendix xiii) evidences that IDVA's will generally obtain more information about risk which again may have been an opportunity for escalation to MARAC and offer a multi agency approach to address his risk within the community. (Please note the recommendations provided in the document at appendix xiii, are included purely to ensure accurate reproduction of the research report.)

Furthermore, in Lancashire the MASH would have linked the former girlfriend at the incident (outlined below) to Adult Z via the constabulary's PVP database and again all victims regardless of level of risk are offered access to a specialist DA service.

There is no evidence any of Adult Z's partners being offered this support and perhaps further intelligence may have been gathered especially around his alcohol and cannabis use which may have prompted a multi agency response through MARAC.

On 26/2/2013, Adult Z appeared before the Magistrates Court in respect of the two charges emanating from the incident in November 2012. He was found guilty and was sentenced on 21/03/2013 to 20 weeks imprisonment, suspended for 12 months with a supervision requirement, a victim surcharge £80, compensation £100, with £400 costs and made subject to a Restraining Order.

On 23/3/13, i.e. two days after his sentence, the WYP received a call from F3 reporting that she had been assaulted by Adult Z. It transpired that, following his conviction, F3 had allowed Adult Z to stay at her home. On the day in question he had been drinking all day and she asked him to leave. An argument ensued and it was alleged that Adult Z had thrown her to the kitchen floor. He then followed her to an upstairs room where he grabbed her by the throat. He then left the address.

The Police attended, their call taker had initially recorded Adult Z's surname incorrectly and therefore the appropriate computer record was not initially accessed. However the attending officers obtained the correct information and the relevant checks were made.

At that time the Police National Computer (PNC) had not been updated with the details of Adult Z's sentence on 21/3/13, this was due to the fact that the Magistrates Court did not update their 'LIBRA' I.T. system until 27/3/13, this then automatically populates the PNC database.

The unavailability of this information may well have impacted on the decision making process of the attending officers and would have impeded their ability to make an accurate risk assessment. (See recommendation 2).

Upon speaking with the attending officers, F3 retracted her allegation of assault but informed them that she had called the Police in order to have Adult Z removed from her house. She did not disclose to the officers at that time that she and Adult Z had previously been in an intimate relationship. As a consequence the DASH process was not commenced.

Notwithstanding the retraction of the allegation, the officers nonetheless made a search of the area in attempt to find Adult Z. They were unsuccessful.

With the benefit of hindsight, if the officers had questioned F3 to a greater degree they may have established the existence of the previous intimate relationship. Potentially this would then have lead to a DASH risk assessment and the possible arrest of Adult Z for breach of his licence conditions.

It is worth noting that there is no information to suggest that, during their previous relationship, F3 had been a victim of domestic violence.

West Yorkshire Police interviewed the officers regarding this incident. Both had received Domestic Violence and DASH training and, with the information available to them at the time, the force concluded that they had applied the correct procedures.

The DHR does not seek to criticise them.

Paragraph 4.1 of the WYP IMR states;
'The West Yorkshire Police response to the historical involvement with Adult Z was compliant with policy.' (See local recommendation 1).

The WYP IMR details the comprehensive training programme delivered to officers with regards to developing awareness and effective action in Domestic Violence cases.

3.2 West Yorkshire Probation Trust. (WYPT)

The Trust became involved with Adult Z following his conviction on the two counts of S39 Assault in February 2013.

Adult Z attended his appointment and a pre-sentence report was completed. The format of the report complied with standard procedure and various sources of information and evidence were used to formulate a risk assessment and sentencing proposal. Previous convictions, records relating to previous periods of supervision and records of previous domestic violence call-outs were clearly sighted and under-pinned the author's assessment

The Pre-sentence report author clearly highlighted his propensity to use violence including elements of both reactive and instrumental violence. The author was explicit in assessing dynamic risk factors of emotionally charged situations and the potential disinhibiting effects of alcohol or drugs misuse. The author appropriately identified the need for interventions to address the issue of domestic abuse.

The proposal made was clearly informed by the analysis. The report author recommended a sentence that would provide an opportunity for monitoring of behaviour, support risk management and provide scope for rehabilitative work to be undertaken both on a one-to-one basis and by completion of a programme designed to target the specific violence displayed in the index offence. The report author also explicitly requested the Court impose a Restraining Order to afford the victims a level of protection which is indicative of good practice.

Once the Order was imposed, the Offender Manager was persistent and robust in her approach to the offender, ensuring that he was aware of his duty to comply with the Order. Good practice was demonstrated in the Duty Officer's insistence that the offender report initially to West Yorkshire Probation Trust before any approach would be made to Lancashire Probation Trust to transfer management of the Order. This enabled an informed approach to be made to Lancashire Probation Trust citing the reasons for re-locating, details of address and occupants of household. Prompt contact was then made with Lancashire to secure reporting instructions, in line with transfer procedures.

The Trust IMR correctly recognises the good practice evident in the offender manager's involvement in this case. All processes were undertaken in a timely manner. There is evidence that, upon being informed of Adult Z's intention to move in with the victim, the manager made contact with Adult Y to confirm that the proposed move was to his agreement. However it is clear that there is no obligation placed on the Probation Service to undertake a risk assessment of the address to which the offender is released. (See recommendation 1).

3.3 Twin Valley Homes (TVH)

Twin Valley Homes received an application for re-housing from the victim, Adult Y, in January 2012. From that date forward the victim was supported through established procedures, eventually being allocated a property in the Darwen area.
Further to his deteriorating health, Adult Y later made a further application for re-housing to a property more suitable to his welfare requirements. At the time of his death the victim was in the process of making arrangements to relocate into the property which had been allocated to him.

The TVH IMR examined all their interactions with the victim and found that all standards had been met.

Neither the victim, nor the perpetrator had informed TVH that Adult Z had moved in with Adult Y, though this omission is not considered to be an issue and would not have resulted in action from the company had they been made aware.

An official from TVH visited the victim at his home address on 25/3/13 to complete documentation in respect of his move to the new property. At that time Adult Z was present but the room shortly after the official's arrival. Adult Y informed the official that his son was there to help him pack for his move. Adult Y made no complaints or raised any concerns about his son with the official.

3.4 Lancashire Constabulary (LC)

Lancashire constabulary had had no contact with Adult Z prior to the death of Adult Y.

The force was first contacted by the Ambulance Service control regarding this incident at 3.18am on Saturday 31st March 2013. They were informed that an ambulance was standing by at a rendezvous point in the vicinity.

Officers arrived at the scene at 3.33am, fifteen minutes after receipt of the call, the nearest available patrol having been a significant distance away. The response time met with the Constabulary's published aim for Grade 1 incidents.

Upon arrival the officers were met by the witness Adult A who directed them to the location of the victim. The scene was secured and preserved in accordance with standard practice.

The officers quickly established the identity of the perpetrator and commenced enquiries to trace Adult Z.

At 3.49am that same morning, Adult Z telephoned the police control room and stated his intention to 'hand himself in.' However he stated that he wasn't aware of the location of the police station. The call taker advised Adult Z to make his way back to his father's address and wait outside the property. The LC IMR identifies this advice as inappropriate – if followed there would have been implications for the safety of the witness, contamination of the scene and risk of loss of evidence.

The IMR states "*The Contact Management Staff have not been interviewed during the course of this review therefore the rationale for the dissemination of that advice has not been analysed.*"
The panel take the view that this matter is worthy of further investigation.(See Local Recommendation 3).

Officers were able to intercept Adult Z and he was arrested and subsequently interviewed, charged appeared before the Crown Court.

The DHR found no issues of concern with regards to the investigation process.

3.5 Northwest Ambulance Service. (NAS)

The witness Adult A made an emergency call to the Ambulance Service which was received at 3.11am on Saturday 31/3/13. The initial call identified that her brother (Adult Z) had beaten up her father (Adult Y) and at that time both men were still in the house at the address given.

At 3.13am an ambulance was despatched to the scene. The incident was rated Red 1 which attracts a government response time of 8 minutes. At 3.16am The attending crew were instructed to stand by at a rendezvous point in the vicinity of the incident to await police attendance.

This instruction was based on a risk assessment conducted by the controller from information obtained from the witness, Adult A. There was no mention of weapons being used at the scene. The controller was operating within existing policy. However it would appear that the policy is enforced without the opportunity for a potentially beneficial, dynamic assessment from staff on the ground, to be included in the considerations.

The result was that the ambulance crew arrived at the rendezvous point at 3.18am but were then delayed from attending to the victim for a further 15 minutes. In the event this delay has not been a contributory factor in the victims death, however it is clear that the policy is worthy of review. (See recommendation 3).

From receiving the initial call, the call taker maintained constant contact with Adult A. During this period Adult Z was continuing to assault Adult Y and had

dragged him from the house into the street. Adult A was continuing to witness the assault and was becoming increasing distressed to the point of hysteria. Once the perpetrator had left the scene, the call taker requested Adult A to examine her critically injured father. It is fair to say that the call taker would not be aware of the victim's condition, however it would have been clearly evident that Adult A was in an extremely distressed state and, as it transpired, found it extremely difficult to comply with the request.
It is difficult to reconcile the decision to ask a clearly vulnerable witness to return to attend to a seriously injured person, with that whereby a double crewed vehicle is directed to standby for health and safety reasons. (See Local Recommendation 2).

3.6 Lancashire Probation Trust (LPT)

The Lancashire Probation Trust had had no physical contact with either Adult Y or Adult Z prior to the event subject of this review.

LPT had initially received notification from WYPT of Adult Z's relocation into their area on 27/3/13 and had immediately taken steps to establish contact, by writing to him to arrange an assessment.

The LPT review notes that part of the transfer process involves an assessment of the suitability of the proposed address. In this case the incident had occurred before those arrangements could be put in place.

However the IMR also notes that "There was no indication of any risk to the victim at first contact, in fact the reason given for the transfer was for the perpetrator to help to look after his terminally ill father".

This observation is in accordance with that provided by WYPT.

3.7 The East Lancashire Hospitals Trust (ELHT)

The trust had had no contact with Adult Z and therefore the IMR referred only to their treatment and care of the victim, Adult Y.

The review examines their involvement with Adult Y from March 2012 to the date of his death.

The document catalogues the extensive treatment given to Adult Y subsequent to his cancer diagnosis, there is nothing contained within the chronology which gives rise to concern in respect of this Domestic Homicide Review.

In addition to addressing his medical needs, the ELHT chronology contains examples of good inter-agency working, particularly concerning the victims housing issues.

On one occasion, whilst a hospital in-patient and perhaps borne out of frustration due to his situation, Adult Y was verbally abusive towards hospital staff and also to his daughter, Adult B. The matter was not reported to the police.

The ELHT IMR makes reference to the vulnerability of the victim due to his ill

health and homelessness, it is clear however that good inter-agency working was able to address the homeless issue.

3.8 Lancashire Care Foundation Trust (LCFT)

The LCFT had no contact with Adult Z.

Their contact chronology commences in April 2012 and continued until 28th March 2013. The review is particularly detailed and provides examples of good inter-agency working to address the developing needs of Adult Y.

District Nurses from both the Health Outreach Team and Community Nursing Services visited the victim on a weekly basis up until the time of his death. There were no records of other family members being present during any of these visits.

The District Nurse considered Adult Y to be very likeable, pleasant and amiable and easy to talk to. He reported to her that he was lonely and gave her the impression that he had a small group of friends that were part of his social circle. He attended the Thomas Project in Blackburn which was a drop in centre attached to the church where he could get a free hot meal daily and would meet the staff from the Health Outreach Team there. He never mentioned to her that he had a son, he did however say that he was close to his daughter, Adult B.

The IMR makes reference to the fact that Adult Y was not considered, by the agency, to be vulnerable and in need of safeguarding. He had demonstrated his ability to understand or make decisions regarding his care and he did not display a reduced capacity, though he did have some difficulties in performing some routine physical activities e.g. getting in and out of the bath and general mobility. It is clear from the review that actions were taken to address these matters.

The LCFT IMR demonstrates the comprehensive detail contained within their records. There is clear evidence of good inter-agency working.

Of particular note is the reference to the Community Nurses undertaking holistic assessments of their 'Service Users'. Such an assessment was undertaken on Adult Y and was reported as follows;

'Patients seen by the Community Nursing Service have an initial holistic assessment by a registered nurse to identify their nursing needs. These findings are documented in assessment documentation and care plans are implemented according to the needs identified. It was reported to the Authors that the Adult Y had care plans in place for: Peripherally Inserted Central Line Care (PICC) and Emotional Support.

The Emotional Support Care Plan would routinely include not just support for the patient but for the family as well. The Service User was encouraged to talk openly about their concerns and mood assessed at each visit. At no time did the Adult Y discuss family relationships or advise that he was close to any members of his family despite opportunities that arose as part of the implementation of the Emotional Support care plan. Staff interviewed as part of the review process consistently reported that he presented as living alone with no close family ties. He talked of a close friend but no carer's assessment took

place as none were identified or disclosed by the Service User. The community nurses reported that Adult Y was going about his normal life, he was independent and had recently been talking about opening a pub with friends. There was nothing to indicate there was a need for increased family or carer involvement.'

This presents clear evidence of the high level of care and support provided to Adult Y and, although there are inconsistencies with regards to accounts of his family ties, it also supports the supposition that he was vulnerable only on the basis of his ill health.

The LCFT IMR identified a small number of minor service delivery matters unconnected to the DHR but considered worthy of addressing at a local level. These matters have been 'action planned' and are documented in the recommendations section of this report for information only.

3.9 NHS England – Lancashire Area Team (LAT)

The LAT IMR is a relatively short document based on the limited contact between Adults Y & Z and their respective GPs.

There are no records held which pertain to matters surrounding this DHR.

The document makes reference to substance abuse by Adult Z but this apparently stopped in 2012.

3.10Blackburn, Darwen & District Womens Aid (BDDWA)

BDDWA had no contact with Adult Z.

Their records contain reference to Adult Y and concerned an incident in 2009 where he used domestic violence on a former partner. He was subsequently made the subject of an injunction and the agency dealt with the partner on an advisory basis.

The circumstances did not have any direct bearing on the matters pertaining to this Domestic Homicide Review, however the IMR did identify shortcomings in their original service delivery. Recently introduced working practices will address those shortcomings.

3.11 The East Lancashire Hospice (ELH)

The ELH had no involvement with Adult Z.

Adult Y had been referred to the Hospice following his cancer diagnosis. The referral procedure was appropriately followed.

The Hospice have identified a number of procedural issues with regards to their care of Adult Y, these are not relevant to the DHR but resulted in the organisation undertaking an audit to ensure that the issues were isolated and not systematic.

3.12 Diversity

The victim and perpetrator were both white, British, heterosexual, males. There are no indications of particular affiliations to any religious or political bodies. There is nothing within this review to indicate that the incident occurred as a result of any factors external to their domestic environment.

3.13 General Analysis

Adult Y lived a chaotic lifestyle, he fathered four children by different mothers, he was a heavy drinker and had some history of domestic violence against some of the women with whom he had relationships.

The DHR panel considered studies which have shown that children brought up in an environment of domestic abuse are statistically more likely to be abusive themselves. (Brown& Bzostek 2003).

However, given the young age at which Adult Z became separated from Adult Y and the fact that he wasn't witness to any such abuse, it is unlikely that those studies are applicable in this case.

It is therefore likely to be coincidental that, in adulthood, Adult Z displayed similar traits to Adult Y in that he was a heavy drinker (family members have described him as being alcohol dependant), and he had a tendency to resolve domestic issues by using violence towards his partners.

The police investigation established that members of the family of the two men were aware of tensions between them and that Adult Z had threatened to harm his father, however they viewed them as idle threats and were not sufficiently concerned to either contact the police or seek support from another relevant agency.

4. CONCLUSIONS:

The circumstances of this case cause the Panel to conclude that no-one could have predicted the extreme nature of the assault which Adult Z inflicted on his father Adult Y. Though both men had a propensity towards violence, with the exception of apparently idle threats (or believed to be so) made by Adult Z in messages to various members of his family, there had been no indicators in the run up to, and including the evening of the attack that would have suggested that he intended or would resort to such savage actions.

The victim had received good agency support from the moment he came to notice and particularly following his cancer diagnosis, this support had included re-housing, daily welfare visits and weekly healthcare meetings.

The perpetrator was unknown to the key agencies in the Blackburn with Darwen area prior to 27th March 2013 when the Lancashire Probation Trust received notification, from their West Yorkshire counterparts, of his relocation. Despite his frequent contact with the various agency staff, Adult Y never mentioned Adult Z, with the exception of one brief introduction to a housing official. On that occasion Adult Y had said that his son was there to help him prepare for his move to his new home.
The victim did not make any report or raise concerns regarding Adult Z to any agency.

The perpetrator had a history of using domestic violence over a period of four years prior to this incident. The common factors in most of those cases were his consumption of alcohol, and all his victims were female partners. His sister has subsequently expressed the view that he was alcohol dependant. On this occasion he had consumed alcohol but not an excessive amount and was certainly not drunk.

All of the previous domestic violence incidents involving Adult Z had occurred on the West Yorkshire police area. The Constabulary had managed those matters in accordance with their existing procedures and the national DASH process. However the Panel is concerned that the risk assessment process appears to have viewed incidents in isolation and therefore may have missed the opportunity to instigate MAPPA/MARAC interventions at an earlier stage. During their IMR, the Force examined its training programme in respect of Domestic Violence and was satisfied that it is fit for purpose.

The review has established that the NHS agencies did not have involvement with either the victim or perpetrator which was in any way relevant to the circumstances in the case, though the process has provided useful information with regards to background circumstances. Their Individual Management Reviews resulted in a small number of local recommendations which have been addressed.

The West Yorkshire Probation Trust performed their role in this case to a high standard. The pre-sentence report presented to Kirklees Magistrates was detailed and contained appropriate recommendations. Once the case had been concluded and they became aware of Adult Z's intention to relocate to Lancashire, the relevant notification was made in a timely manner and had been prioritised due to the impending public holiday.

The Panel have considered whether or not the death of Adult Y was preventable. They concluded that it may have been so, but only if certain events had different outcomes i.e:

1. That the information concerning the conviction and sentence of Adult Z on 21/3/13 had been available to the officers attending the incident on 23/3/13 involving SH.
2. That SH had revealed to those officers her previous relationship with SH and had pursued her allegation of assault.
3. That , in possession of the above information, the officers' had located and arrested Adult Z and referred him to the Probation Service.
4. That the Probation Service revoked Adult Z's licence and placed him before the Court.
5. That the Court remanded Adult Z into custody.

It is clear that the actual circumstances were significantly different but there is no blame to be attached to any of the agencies involved. The recommendations appended to this report are intended to minimise the possibility of a repeat of any similar occurrence.

Her Majesty's Court Service is not included in the list of persons and bodies to which Section 9, Subsection 4 of the Domestic Violence Crime and Victims Act 2004 applies. The circumstances of this case lead the panel to conclude that, whilst recognising the necessary independence of the Courts in respect of the criminal process, it is likely to be beneficial to future reviews for the service to

be represented. The panel requests a Home Office view on this proposal.

6.1 Key Issues arising from the review

- There was no history of violence between the perpetrator and victim. The victim, Adult Y, had historically used violence against a number hisf partners, though there is no evidence that he mistreated his children. Studies have shown that children brought up in an environment of domestic abuse are statistically more likely to be abusive themselves.(Brown& Bzostek 2003).

  However, given the young age at which Adult Z became separated from Adult Y and the fact that he wasn't witness to any such abuse, it is unlikely that those studies are applicable in this case.

  Adult Z had a propensity to use violence to resolve disputes and his level of violence in the domestic environment was escalating. Adult Z was known to have used cannabis in the past and both men were heavy drinkers (source; police investigation documents/family interview). Adult Z was known to bear resentment of his father (source; family).
  Adult Y was vulnerable but only due to his illness. With hindsight, particularly in respect of the information obtained from the family following the murder, it is clear that in the circumstances, there was a significant risk that problems would arise between the two men and that there was an increased risk that violence would occur. Unfortunately this information was not available to agencies prior to the incident and therefore there was no opportunity for the agencies to make the necessary links to enable the outcome to be predicted.

- On 21st March 213, following the imposition of a suspended custodial sentence for a domestic related assault, the Kirklees Magistrates court released Adult Z to no fixed address.

- Details of Adult Z's conviction at the Kirklees Domestic Violence Court on 21st March 2013 were not entered onto the court's 'LIBRA' I.T. system until 27th March 2013, thereby resulting in a delay in the availability of the information on the Police National Computer.

- Upon being released from court, Adult Z went to stay, temporarily, with a former girlfriend. During the early hours of 23rd March he assaulted her. The Police were called to the address but were not made aware by the complainant that she had previously been in an intimate relationship with Adult Z, had she done so this may have triggered the DASH process. By the time the police arrived at the address Adult Z had left. This being her desired outcome, the complainant withdrew her allegation of assault. The police made efforts to find Adult Z but were unable to do so.

- Following the emergency call to the Northwest Ambulance Service regarding the assault on Adult Y, an ambulance was promptly despatched to the scene. However the attending crew were advised to stand off from the scene pending police arrival. This advice was based on a risk assessment undertaken by the radio operator and resulted specifically from the information received from the witness that the

perpetrator was still at the scene. The purpose of the advice was to maintain scene safety of the attending paramedics. The arrival of the ambulance to the scene was thereby delayed for 15 minutes.

- During the emergency call to the Ambulance service from the witness at the scene, the operator directed the witness, who was in a state of hysteria, to return to the scene and assess the condition of the victim.

- The perpetrator telephoned the police indicating an intention to surrender himself. The police call taker/communicator advised the perpetrator to return to the crime scene, potentially compromising the safety of the public and risking contamination of the scene and other evidence.

5 RECOMMENDATIONS:

National Recommendations.	
1	**H.M.C.S.** **Where, in a case involving domestic violence/abuse, a court is intending to sentence an offender to either a suspended prison sentence or other community punishment involving a supervision requirement, it should be a mandatory requirement that the court is supplied with a suitable address to which to release the individual concerned. The address supplied should be subject of a risk assessment prior to case conclusion. Where no such address is able to be supplied, agency support should be available to assist the offender in securing approved accommodation. Having regard to the ongoing restructure of the providers of rehabilitation services, the Home Office may wish to undertake a study to identify the most appropriate vehicle with which to deliver this recommendation.**
2	**H.M.C.S.** **In recognition of the increased risk of reoffending associated with those convicted of domestic violence offences, in order to further protect the victims, consideration should be given to the introduction of a National Service Level requirement to ensure that all convictions for domestic related matters are updated on the relevant IT systems within 24 hours. This move would align the process to that of other high risk groups.**
3	**NHS Ambulance Trusts** **The Ambulance Service review the risk assessment process undertaken in respect of their attendance at incidents, to establish whether it achieves the correct balance between the safety of their staff and the needs and welfare of the patient.**
Local Recommendations	
1	**West Yorkshire Constabulary review their internal processes to ensure that the analysis of Domestic Violence Cases, particularly within their Safeguarding Units, is sufficiently robust so as to identify serial offenders and correctly apply the rating matrix, to ensure that appropriate cases are referred to MARAC/MAPPA.**

2	**<u>Northwest Ambulance Service Trust</u>** **To review their policy/procedure/training in respect of directing members of the public to examine patients in situations such as the one subject of this review, to ensure that consideration is given to the vulnerability of the person being directed.**
3	**<u>Lancashire Constabulary</u>** **To review the advice given, in this incident, for Adult Z to return to the crime scene and establish whether this incident is an isolated mistake or highlights a general training issue in respect of Call Takers and Radio Operators.**
IMR Recommendations (included for information only).	
1	<u>Lancashire Care NHS Foundation Trust</u> The Community Nursing Service review procedures in regard to bereavement visits/family contact to ensure support for families following any death not just those receiving end of life care.
2	<u>Lancashire Care NHS Foundation Trust</u> Findings of the report are fed back into the Professional Nursing Forum and AHP forums to support learning across all the services and recognition of the good practices identified
3	<u>Lancashire Care NHS Foundation Trust</u> Reduce the incidence of loss / destruction of patient held records by reiterating verbally and in writing to each patient how patient held records are cared for and retained.

6 Glossary

Acronym/Abbreviation	Meaning
DASH	Domestic Abuse Stalking and Harassment/Honour based violence.
DHR	Domestic Homicide Review
HMCS	Her Majesty's Court Service
IMR	Individual Management Review
MAPPA	Multi Agency Public Protection Arrangements
MARAC	Multi Agency Risk Assessment Conference