

Safer North Tyneside Partnership

DOMESTIC HOMICIDE REVIEW

OVERVIEW REPORT

**INDEPENDENT REVIEW REPORT INTO THE DEATHS OF
SARAH AND JOHN**

Date of Death February 2014

Report produced by:

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1. **Introduction**

- 1.1 This report concerns a Domestic Homicide review into the deaths of Sarah and John who died in their home in North Tyneside in winter 2014. The review considers agencies contacts with Sarah and John as well as Mark their grandson and son respectively who was responsible for their deaths.

The Homicide Incident

- 1.2 On an evening 2014 police were called to an area in North Tyneside where members of the public had detained a man, now known to be Mark, after he was seen running among traffic apparently in an effort to self-harm.
- 1.3 On arrival of police, Mark told them he had killed his grandmother and father and that their bodies lay in their home nearby.
- 1.4 Within their home police found the **dead** bodies of Sarah, grandmother of Mark and John, the father of Mark. Both Sarah and John had suffered multiple injuries and some mutilation. Various bladed weapons were found at the scene.
- 1.5 Mark was arrested and subsequently charged with the murder of Sarah and John. At the time of his arrest Mark was seen to be displaying behaviours which indicated the presence of a mental illness. This included; confusion, laughing inappropriately, spitting at people and speaking in a rambling incoherent manner. Later while in custody he was examined by two psychiatrists who after a number of consultations, diagnosed Mark as suffering from a major mental illness in the form of Schizophrenia, attended by hallucinations, paranoia and persecutory delusions. In June 2014 Mark pled guilty to manslaughter on the grounds of diminished responsibility and was ordered to be detained in a secure hospital without limit of time.

2. **The Domestic Homicide Review Process**

- 2.1 Agencies in North Tyneside had limited involvement with the family but due to the nature of the incident the case was referred for a Domestic Homicide Review.
- 2.2 Domestic Homicide Reviews (DHRs) were established on a statutory basis under Section 9 of the Domestic Violence, Crime and Victims Act (2004), which came into force in April 2011.
The purpose of the DHR is to:
- Establish what lessons are to be learned from the domestic homicide and ways in which local professionals and organisations can work individually and together to safeguard victims;
 - Identify clearly what those lessons are, both within and between agencies, how they will be acted on, including timescales, and what is expected to change as a result;
 - Apply these lessons to service responses including changes to policies and procedures as appropriate; and

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

These reviews are not inquiries into how the victim died that remains a matter for the judicial system to determine.

2.3 Northumbria Police referred the deaths of Sarah and John to the Chair of North Tyneside Strategic Partnership for the case to be considered for a Domestic Homicide review. The Chair confirmed with the Home Office that this case met the criteria and that a DHR would be undertaken.

2.4 **Domestic Homicide Review Panel**

Following the decision to carry out a review, a DHR Panel was convened and met for the first time on 25 April 2014.

The DHR Panel is tasked with overseeing the process. The panel/IMR chronology writers consisted of the following individuals:

- Dr Stephen Blades, GP Lead for Adult Safeguarding, NHS North Tyneside Clinical Commissioning Group
- Val Short, Assistant Principal, Longbenton Community College
- Heather Carmichael, Northumbria Healthcare NHS Trust
- Joan Robson, Northumbria Police
- DCI John Douglas, Northumbria Police
- Anna Stabler, Public Health England
- Frances Blackburn, Newcastle Hospitals
- Lesley Thirwell, North East Ambulance Service

2.5 The agreed period of time subject to review was between 1998 and 2014, the date of death of Sarah and John.

2.6 The DHR Panel met on the following occasions:

- 25 April 2014
- 18 July 2014
- 2 September 2014
- 12 November 2014

2.7 In addition, Tom Wood was commissioned to independently Chair the Panel and write the overview report. He is currently an independent chair of two Adult and Child Protection Committees in Scotland, and was the Deputy Chief Constable and Director of Operations of a large police force in Scotland. He has also previously acted as both chair and overview report writer in both Serious Case Reviews and Domestic Homicide Reviews.

2.8 **Individual Management Review/Chronologies**

Due to the limited involvement with the family Individual Management Reviews were only required for the General Practitioners representative and Northumbria Police.

In addition, chronologies were prepared by:

- Longbenton Community College – attended by Mark
- North Tyneside General Hospital A & E
- Northumbria Healthcare NHS Foundation Trust – hospital
- North Tyneside Adult Social Care

At a late stage in the DHR process (November 2014), two confidential psychiatric reports were made available to the Independent Chair/report writer. These reports contained considerable detail not known to the DHR before that time. Consequently the DHR process was delayed while this new information was considered.

- 2.9 The Independent Chair met with IMR/Chronology authors at the start of the process when a full discussion on the case details took place. Thereafter review/chronology authors were invited to subsequent meetings to discuss and present their findings. Throughout the process the Independent Chair shared and discussed his findings with review/chronology authors.
- 2.10 The Independent Chair was provided with a number of additional documents:
- Northumbria Police – case summary
 - Confidential Psychiatric Report and subsequent psychiatric comment Appendix compiled by Professor Don Grubin
 - Confidential psychiatric report compiled by Rajesh Nadkarni

2.11 **Family Involvement**

The family of Sarah, John and Mark were contacted first by police then by the Independent Chair when the purpose and process of the DHR was explained. While Tony, the son of Sarah, brother of John and uncle of Mark was helpful and supportive of the DHR process, Joanne, the ex-wife of John and mother of Mark declined to be involved with the DHR process, **despite numerous attempts to contact and engage with her.**

Notwithstanding, both family members were kept informed of the progress of the DHR. **Tony has been made aware of the conclusions and recommendations of this report.**

2.12 **Review Timings**

Due to the difficulties tracing all Mark's medical records and the late access to two psychiatric reports it was not possible to complete the review in the six month time period as set out in the guidance. The Board of North Tyneside Strategic Partnership were continuously updated as to the progress of the review.

3. Family Background

- 3.1 **Hard evidence relating to relationships within the family has been difficult to obtain or confirm. One family member has contributed to the review and while helpful could not describe the dynamics of the family in the immediate period leading up to the deaths of Sarah and John. Likewise, local agencies had limited contact with the family and held no current information about relationships within the family before the deaths.**

This review is therefore based on the limited information available from police, court and medical reports compiled after the deaths. While Mark's own account is reflected in the medical reports, this review has had no direct access to the perpetrator Mark.

- 1.2 The family comprising Sarah (deceased), her sons John (deceased) and Tony lived at the same address in North Tyneside since 1974. John, the husband of Sarah and the father of John and Tony died in 1994.
- 1.3 Sarah, (deceased) **worked** as a mental health nurse until her retirement. Subsequently she suffered ill-health and at the time of her death had a number of chronic health problems including hypertension, osteoporosis and spinal stenosis. Despite her poor health she continued to live independently and there is no evidence to suggest that she lacked the capacity to care for herself.
- 1.4 Tony (witness) left the family home in the 1970's and though resident in London since, kept regular contact with his family, particularly his mother (Sarah) visiting her in North Tyneside and telephoning her regularly. Sarah also visited Tony in London sometimes in the company of other members of her family.
- 1.4.1 John, (deceased), the eldest son of Sarah worked with his father in the building industry as a young man, then with the local council as a general repair man.
- 1.4.2 In about 1987, John began a relationship with Joanne (declined to assist) and shortly afterwards they began living together. Subsequently Joanne fell pregnant. Mark was born in 1988 at 33 weeks with a birth weight of 2.5kgs. His development, sitting, standing, walking and speaking were all slightly delayed but within the normal range. He was treated for Asthma and dermatological problems as a child but there is no history of any referral for mental health issues.
- 1.4.3 While the relationship between John and Joanne was initially stable it soon became tempestuous. Mark described his mother as a 'bad copier'. There were several separations between John and Joanne when John returned to his parents' home leaving Mark with his mother. Eventually Joanne was unable to **care for** Mark and he went to live with his father and grandmother (Sarah and John).

- 1.4.4 Around 1998, Joanne and John separated permanently and John took custody of his 10 year old son Mark. He returned him to his old family home where Sarah assumed the maternal care of Mark (her grandson). From that time the relationship between Joanne and the rest of the family became increasingly fraught and Mark saw his mother infrequently.
- 1.4.5 Around the same time (1998/99), both Sarah and John's (deceased) health began to decline and it became more difficult for them to care for the teenage Mark. Despite this, throughout his early teens, Mark was cared for and **was** well behaved **at school** though quiet and without many friends.
- 1.4.6 After completing his schooling with average results but reasonable behaviour and strong interest in artistic subjects, Mark attended an art course at a local college. It is about this time that his family saw a change in Mark's behaviour. They suspected that he was drinking alcohol heavily and perhaps misusing drugs especially Cannabis. Whatever the cause, Mark became occasionally aggressive in his attitude towards Sarah and John. On one occasion an aggressive though non-violent argument led to an intervention by Tony , Mark's uncle, which appeared to resolve the matter with no further aggressive incidents reported.

It should be noted that psychiatric examinations of Mark, post arrest, also identify this time as the point where Mark's behaviour/mental health **appears** to deteriorate.

- 1.4.7 In 2009 Mark moved from the family home to attend a Video Arts Course at the Southbank University, London. He initially moved into the halls of residence but because of odd behaviour (not further described) was moved to a floor of the halls on his own. He was also arrested but not charged following a fire in one of the kitchens in the halls. During this time Mark returned periodically to the family home in North Tyneside. By this time Sarah and John's health had deteriorated further and while they were able to care for themselves they were unable to deal with Mark who **reportedly** continued to drink heavily, spend long periods on the family computer and appear reluctant to seek employment or otherwise engage with the outside world.
- 1.4.8 At the time of their deaths Sarah and John were struggling to cope with Mark. Their health was fragile and while they continued to support him his behaviour, while always apparently non-violent, had become more difficult to live with or control.
- 1.4.9 A picture emerges of Sarah and John as caring people in deteriorating health doing their best to cope with an increasingly troubled and difficult Mark. While these difficulties may have included confrontations and on at least one occasion aggressive argument, there is no record or suggestion of physical violence let alone the level of violence displayed in the deaths of Sarah and John.

It should be noted that until the time of her death Tony enjoyed a close and regular **telephone** contact with Sarah, his mother. **This witness** is certain

that if any violent or incident of serious mental disturbance had taken place, he would have been made aware of it.

2. Perpetrator

The information in this section has been abstracted from information provided by a family member and from police and health/psychiatric reports partly based on interviews with the perpetrator.

- 4.1 The perpetrator in this case is Mark. He was arrested near the scene of the homicides of his father John and his paternal grandmother Sarah. Subsequently he was **convicted of Manslaughter on the grounds of diminished responsibility as described earlier in this report.**
- 2.2 Mark was born in 1988, the only child of John (deceased) and Joanne (declined to assist this process). **In** his own account Mark alleges that from an early age his childhood was disrupted by conflict between his mother and father. **His account is uncorroborated but suggests a degree of emotional abuse.**
- 2.3 A family account suggests that Mark lived with his mother and father in North Tyneside until the age of 5 when his father (John) left following **domestic** arguments. For the next 5/6 years Mark was brought up alone by his mother with intermittent visits by his father. During this time Mark recalls often being confined to his room for fear of upsetting his mother. Finally when Mark was 10/12 years old his mother **found** that she was unable to bring him up alone and he was given into the custody of his father (John) returning to live with him and Sarah in the family home in Longbenton.
- 2.4 At this time there is no suggestion that Mark was badly behaved, aggressive or disturbed. **It is suggested** that the return of Mark to his father was more to do with his mother's inability to cope, rather than issues with Mark's behaviour.
- 2.5 Mark settled well with his father and grandmother and while relationships with his mother were still fraught his contact with her became infrequent and he **enjoyed** a stable upbringing with his grandmother (Sarah) assuming the main parenting role.
- 4.6 Mark was reasonably settled at both primary and secondary schools. His school record shows some minor behavioural problems but none that required serious disciplinary measures. He had a small group of friends and did reasonably well academically, gaining several GCSEs and three A levels. During this time Mark did not display any symptoms of behavioural or emotional disturbance.
- 4.7 On leaving school Mark continued to live in the family home and though he worked briefly in mundane jobs he failed to settle in an area of employment, finding a "lack of challenge." Later he pursued courses in communications at

a local college and film making (Southbank University) but never found an area of work that was successful.

- 4.8 It appears that it was after he left school, when he was about 18 years old that Mark's behaviour changed and became more disturbed. A family account indicates that it was at this time he began to drink alcohol heavily and perhaps use drugs, particularly Cannabis. It is in this period that Mark became more assertive and aggressive to his increasingly frail father and grandmother.
- 4.9 Although the changes in Mark's behaviour was mainly dealt with within the family, the police logs at the time show four calls from John and Sarah reporting drunken and disorderly behaviour by Mark. He was arrested during one of these incidents but released when John and Sarah declined to give statements to police. It is about this time that Tony (his uncle) confronted Mark about his behaviour and this appears to have resolved the situation, there being no further reports of aggression within the family. There was one further call (June 2009) from Sarah to report Mark's abusive behaviour but no further reports of aggression and Mark then appears to have become reclusive, remaining in his room and spending long periods of time on the family computer.
- 4.10 In 2009, when he was about 21, Mark left the family home in North Tyneside and moved to London to study film making at Southbank University. As previously noted, he first lived in halls of residence but after odd behaviour (**not further described**) he was allocated a room in a hall of his own. His drinking remained a problem and he sought treatment for this and depression/low mood on a number of occasions. **By his own account** he also apparently engaged in **a number of casual homosexual relationships** while in London, this being the first suggestion of issues with his sexuality.
- 4.11 Despite these issues Mark lived for two years in university halls of residence and while there were obviously concerns, he apparently completed his first year Foundation Course and paid attention to his studies.
- 4.12 By 2012 Mark's behaviour was again problematic. He was arrested but not charged with fire-raising within a kitchen in his halls of residence and was reported to **suffer from** poor personal hygiene.

Mark moved from halls of residence to share a flat with a friend but this ended in his squatting in the property when the landlord apparently went bankrupt. **He briefly found work** as a dog walker but found this unsatisfactory and soon gave up.

- 4.13 Mark returned to the family home in North Tyneside to stay with Sarah and John over Christmas. He spoke of giving assistance to Sarah and John whose health he recognised was failing. In the event he stayed beyond the Christmas holidays until the date of Sarah and John's death.

5. Relationship between Perpetrator and Victims

- 5.1 The relationship between Mark, the perpetrator and his victims Sarah and John was paternal grandson and son respectively.
- 5.2 The nature of the relationship between Mark and his grandmother and father is documented in Sections 3 and 4.
- 5.2.1 In summary, Mark had a troubled early childhood most likely affected **by the breakdown of his parents' relationship**, although the true extent **and nature** of this **is uncertain**.

It is clear, however, that once he moved to live with Sarah and John (about 10 years of age) Mark was given a secure and supportive home and by all accounts he thrived during this time, and lived a normal and balanced early teenage life.

- 5.2.2 There **appears little** doubt that Mark's troubles started to **emerge** when he was about 18 years of age and began drinking alcohol heavily and perhaps using Cannabis. The specific issues surrounding Mark alcohol/drug use will be discussed in a later chapter but it is at this time that Mark's behaviour changed and he became assertive/aggressive to his grandmother (Sarah) and father (John).
- 5.2.3 While there were indications of tension between Mark and his grandmother and father, these were seen both within the family and by agencies as minor. There was no indication whatsoever that Mark would resort to the extremes of violence that ended with the deaths of Sarah and John.

5 Summary of Agency Involvement

- 6.1 Very few agencies in North Tyneside had involvement with the family and those contacts that were made dealt with routine matters connected with Sarah and John's chronic medical conditions.

The chronology of agencies show routine contacts with no indication of serious problems, violence or the potential for violence.

- 6.2 Two agencies had more extensive contact with the family – police and General Practitioners and these deserve more detailed scrutiny.

6.3 Northumbria Police

On several occasions local police were called by Sarah and John regarding the behaviour of Mark.

These calls all fell into the category of minor nuisance or drunken behaviour and were dealt with routinely by operational officers. On at least one occasion, Mark was arrested but released when his family refused to press charges.

In all these incidents there was no indication of extreme violence or of risk to life. Police dealt professionally and proportionately with these calls. There was no indication of the sudden and catastrophic escalation of violence that ended with the deaths of Sarah and John.

6.4 **General Practitioners**

General Practitioners records for Sarah and John are comprehensive and show the long term care of their chronic health conditions. Significantly there is no indication of injuries associated with violence, or any reports of threats of violence made to Sarah or John.

6.4.1 General Practitioner records for Mark come in two distinct parts. Those records for North Tyneside up to 2009 and those relating to his residence in London.

6.4.2 Mark's early contacts with North Tyneside GPs show **the usual childhood illnesses with** nothing out of the ordinary. Later while a teenager Mark sought help for his alcohol consumption. Help was offered and appointments for further treatment made but Mark failed to attend these appointments and there was no follow up.

The process for dealing with non-attendance at appointments will be dealt with later but it is important to note that nothing in Mark's interaction with GPs in North Tyneside gave cause for concern or any indication of serious mental illness or violence.

6.4.3 Between 2009 and 2012 Mark lived in London and contacted General Practitioners/Psychiatric Services on a number of occasions.

Early contacts (2009) refer to his alcohol consumption and 'low mood' for which he was prescribed antidepressants. His mood improved and he attended a number of cognitive behavioural therapy sessions.

Later in 2010 he again contacted his GP to report a worsening of his mood and binge drinking. Consequently he was referred to psychotherapy.

6.4.4 In 2011 Mark was assessed by a Consultant Psychiatrist with whom he discussed his problems within the halls of residence, his difficulties with relationships, his drinking and his family. He described his relationship with his grandmother and father as having been bad but recently improved. He also discussed his sexuality and his fantasies. The psychiatrist concluded that Mark showed no signs of a depressive illness or psychotic symptoms.

6.4.5 The GP records from London confirm that soon after Mark moved there he experienced mental health problems for which he received treatment, **including** the psychiatric assessment of 2011. No evidence of a depressive illness or psychosis was found. **There was no evidence** that suggested that Mark was a risk to himself or others.

7. Alcohol and Drugs – Sexuality – Mental Health – Schizophrenia

7.1 Alcohol and Drugs

As indicated in previous chapters in this report Mark began drinking heavily from the age of 18 years. By his own account he drank large amounts of alcohol intermittently but also reported periods of abstinence. It is recorded that on several occasions he sought treatment but such treatment was never successfully carried through due to the intermittent nature of his drinking and his failure to attend for treatment.

7.2 While his family believed that Mark was a heavy user of Cannabis and/or Cocaine during his teenage years, the extent of his drug use is unclear. Mark himself stated that he had experimented with Cannabis and other substances but details are imprecise.

7.3 **There can be little doubt as to the serious impact of alcohol on Mark's behaviour. His aggressive behaviour is recorded as starting when he began drinking heavily. Likewise, all the critical incidents that are recorded, including the deaths of Sarah and John, are associated with alcohol.**

7.4. Sexuality

Although unknown to his family, Mark states that he became aware of his sexual orientation at an early age. By his own account there followed difficulties in same sex relationships a number of which involved violence.

During psychiatric examination (post arrest) he spoke of watching extreme pornography and violent action films sometimes repeatedly. He also spoke of having violent thoughts while engaging in sexual acts. While his sexual orientation has no direct connection with the violent deaths of Sarah and John, his violent experiences combined with his alcohol use may have contributed to his deteriorating mental health culminating in the deaths of his father and grandmother.

7.5.1 Mental Health

Although concerns about Mark's mental health first came to attention in 2009, they were considered minor and he was assessed as being at no risk to himself or others. When examined by a psychiatrist in 2011 there was no evidence of depressive illness or psychotic symptoms.

7.5.1 At the time of his arrest, however, Mark displayed signs of a serious mental disturbance, including paranoia, hearing voices, confusion and hallucinations. Following extensive psychiatric examinations while in custody Mark was diagnosed as suffering from a major mental illness in the form of Schizophrenia. Symptoms of Schizophrenia include; delusions, hallucinations and disorganised speech all of which were displayed by Mark, post arrest.

- 7.5.2 In making their diagnosis, psychiatrists could not determine when Mark's mental illness started, his chaotic lifestyle/alcohol abuse making this impossible.
- 7.5.3 What is certain is that at no point prior to the murder of Sarah and John was Mark's mental health or behaviour recorded by family or agencies as dangerous to himself or others.

8. Terms of Reference

8.1 When the DHR was commissioned terms of reference were agreed by the commissioning panel. This section addresses these terms of reference individually.

8.1.1 **Q.** If there was a low level of contact with your agency why was this so? Were there any barriers (particularly ethnic origin, culture or language) to either the victim or accused accessing service or seeking support?

A. In relation to the deceased, both deceased suffered chronic ill-health and accessed health services for ongoing treatment. Neither sought help in relation to their relationship with the perpetrator and a family member confirms that they made no mention of threats within the family.

Both deceased while suffering ill-health, had capacity and while they clearly had some difficulties with the perpetrator in their domestic settings, there is no evidence to suggest they perceived serious risk and accordingly did not seek help.

A. In relation to the perpetrator, the perpetrator sought and received sporadic help for his alcohol consumption and depression/low mood. This contact was low level due to his non-attendance at appointments and the perpetrator moving address causing gaps in service.

There is no evidence to suggest either victims or perpetrator were denied services due to ethnic origin, culture or language.

8.1.2 **Q.** Were there indications of the victims being isolated by the perpetrator and could this have prevented them from accessing service?

A. There is no evidence to suggest that the victims were isolated by the perpetrator. While both victims suffered chronic ill-health and their mobility was limited, they were in regular contact with another family member and had unhindered opportunity to register concern.

8.1.3 **Q.** Were there any other issues relating to this case such as drug or alcohol abuse and if so what support was provided?

A. Both deceased suffered chronic ill-health but there is no suggestion of incapacity, alcohol or drug concerns.

A. The perpetrator had sporadic but severe problems with alcohol. He was under the influence of alcohol at the time of the offence and there is strong evidence to suggest a difficult relationship with alcohol since his teenage years. He accessed treatment for his alcohol problems but failed to attend some appointments and his move of residence exacerbated his continuity of treatment.

The evidence of the perpetrator's drug use is uncertain. On one hand, a family member believed he was using Cannabis and perhaps other substances heavily from his teenage years. On the other hand, there is no independent evidence of drug use and the perpetrator himself admits experimenting with Cannabis but nothing further.

In summary, while the heavy misuse of alcohol by the perpetrator is clearly a significant contributory factor in this homicide, the contribution of drugs is less clear and is likely to be less significant.

- 8.1.4 **Q.** Whether the perpetrator had a history of any violent behaviour and if any referrals were made to services in light of this?
A. The perpetrator had a brief history of aggressive but non-violent confrontations with the victims, but these were not reported formally at the time or thought serious enough by family members to justify formal action.
- 8.1.5 **Q.** Whether any risk assessments had been undertaken previously on the victims or perpetrator and whether these had judged risk appropriately?
A. No risk assessments were carried out by services. No concerns were made known to services or could have been predicted by the information available to services.
- 8.1.6 **Q.** Whether the victims were experiencing coercive control on the part of the accused?
A. While the victims suffered chronic ill-health and their relationship with the perpetrator was sometimes fraught, there is no evidence to suggest coercive control.
- 8.1.7 **Q.** Was there any indication of domestic violence or coercive control occurring before the incident and if so did the victims consider this to be control or domestic abuse?
A. While there were domestic tensions and instances of aggression there is no evidence of violence by the perpetrator towards the deceased prior to the homicide.
- 8.1.8 **Q.** Was there any information held by informal networks?
A. There was no significant information known to services. A family member had regular contact with victims but perceived no risk.
- 8.1.9 **Q.** To what extent did contact and involvement with the victims and/perpetrator result in informal or informal assessment?
A. Services had minor involvement with the deceased and perpetrator. None of this involvement indicated a threat of violence let alone serious violence. Accordingly no assessments were made.
- 8.1.10 **Q.** Did the victims' origin, culture or language impact on services?
A. There is no evidence of any impact caused by origin, culture or language.
- 8.1.11 **Q.** Involvement, role and function of MARAC?
A. There was no involvement by MARAC in this case.

9. **Conclusion and Recommendations**

- 9.1 **It seems impossible that a crime of the gravity and extreme violence as the killing of Sarah and John should happen spontaneously, without warnings or indications to family, friends or agencies in contact with the family. Yet in the case of the this family, all facts known to this review indicate that is exactly what happened.**

Although close to the family and in regular contact with them, the only surviving close family member had no indication of violence or risk. Likewise, agencies who had minimal contact with the family recorded no reports of violence or risk.

The senior psychiatrist who examined Mark (post arrest) is of the view that it may well be that Mark's sporadic heavy alcohol use and withdrawal contributed to his failing mental health and while there is some uncertainty about his Cannabis/drug use, this too may have contributed to his condition.

Notwithstanding, the psychiatrist was of the view that given the level of contact in this case no agency was in a position to predict the deterioration in Mark's mental health or the catastrophic consequences that resulted.

There is no evidence that the deaths of Sarah and John could have been predicted or prevented.

- 9.2 **There were few opportunities to intervene in the life of Mark and for the most part his problems remained hidden.**

We now know that he had a troubled early childhood and while a teenager sought help for alcohol use and later for mental health issues. His lifestyle and the intermittent nature of his drinking made treatment for his alcohol use difficult and unsatisfactory.

He did, however, receive a psychiatric assessment in 2011 which found no evidence of a depressive illness or psychotic symptoms.

In conclusion, the few opportunities for agencies to intervene in the life of Mark were dealt with proportionately given the information at the time.

- 9.3 **When examined by a psychiatrist after the deaths of Sarah and John, Mark was diagnosed to be suffering from Schizophrenia attended by paranoia, delusions and hallucinations. This report also notes that it is not uncommon for signs and symptoms of such a condition to become clear only in retrospect.** Nowhere in the recollections of surviving family members or agency records is there any reference to such a mental state being previously noted in Mark .

- 9.4 **At the outset of this DHR the central question asked was:
"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?”

In this case, the very low level of contact between the victims/perpetrator and services and the lack of perceived threat made it impossible to intervene to protect the victims.

The police had only limited contact with the perpetrator which was coloured by heavy alcohol use while the GP appears to have responded appropriately to the presentation he saw. Mark had no real history of aggression or violence that would have raised alarm.

In addition, the psychiatric examination of Mark in 2011 found no evidence of a depressive illness or psychotic symptoms.

There appears to have been no indication of Mark’s future behaviour. In these circumstances it is difficult to identify significant lessons to take forward.

Recommendations

- 9.5 One issue that has been identified relates to the management of DNAs (did not attend appointments) either at GPs or follow up services. In the case of Mark this was a particular problem as his **intermittent** attempts at self-management of his alcohol problems perhaps led him to believe that he had ongoing control.

Notwithstanding it is recommended that North Tyneside CCG advise all partners to discuss the overall vulnerability of adult patients when considering what follow up actions should be taken in the case of DNAs in any area of the partnership.

Whether such a risk/vulnerability assessment would have raised concerns in the case of Mark is doubtful, such was the lack of any indication of risk in his case. Nevertheless it is believed that in the context of the case real benefit can be gained from multi-agency discussions on general vulnerability in DNA cases where high risk is not always apparent.

Tom Wood
November 2016



Recommendation	Scope of Recommendation	Action to Take	Lead Agency	Key Milestones achieved in enacting the recommendation	Target Date	Date of Completion & Outcome
All Partners						
Community Safety Partnership to work with Safeguarding Adults Board to ask Partners to review their policy and procedures when clients default from service provision (Do Not Attend) to ensure that the vulnerability of the patient is taken into consideration when deciding what action (if any) needs to be taken.	Local	Review Policy and Procedures	Safeguarding Adults Joint Case Review Committee	Review of Policy and Procedures completed.	October 2015	