

THE CONTENT OF THIS REPORT IS RESTRICTED UNTIL PUBLICATION

REPORT INTO THE DEATH OF 'Joe' and 'Iris'

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PREFACE

This Domestic Homicide Review (DHR) was carried out following the death of husband and wife 'Joe' and 'Iris' In December 2014. This was the seventh statutory homicide review carried out in Newcastle. It was carried out in accordance with the Home Office guidance and section 9 (3) of the Domestic Violence Crime and Victims Act 2004.

We would like to convey our profound sympathy to the family and friends of Joe and Iris and assure them that in undertaking this review we are seeking to learn lessons from this tragedy, and to improve the response of agencies in cases of domestic violence. We are grateful for the input of Iris's daughter Charlotte, which provided the review with valuable information.

We would also like to express gratitude to Safe Newcastle and all those who have given of their time and co-operation through this review process as Review Panel members, Individual Management Review (IMR) authors, and staff members of participating agencies who were interviewed as part of the preparation of IMRs.

1. INTRODUCTION

1.1 Background to the Review

1.1.1 This review relates to the homicides of “Joe’ (aged 64) and ‘Iris’ (aged 54) at their home in December 2014. Following their deaths, Northumbria Police commenced an investigation and their son Bob (aged 28) was charged with their murder. Due to the nature of the homicides, having been committed by the victims’ son, the case met the criteria for a statutory Domestic Homicide Review.

1.1.1 This report of a Domestic Homicide Review (DHR) examines agency responses and support given to Joe and Iris prior to the point of their death, as well as agency contact with Bob.

1.2 Purpose of the Review

1.2.1 The purpose of a Domestic Homicide Review, as set out in the Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews, 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 to change as a result.
- Apply these lessons to service responses including changes to policies and procedures as appropriate; and
- Prevent domestic violence homicide and improve service responses for all domestic violence victims and their children through improved intra and inter agency working.

1.2.2 DHRs are not inquiries into how the victim died or who is culpable; this is a matter for the criminal courts.

1.2.3 DHRs are not specifically part of any disciplinary enquiry or process. Where information emerges in the course of a DHR indicating that disciplinary action would be initiated, the established agency disciplinary procedures would be undertaken separate to the DHR process. Alternatively, some DHRs may be conducted concurrently, but separately to, disciplinary action.

1.2.4 As far as is possible, DHRs should be conducted in such a way that the process is seen as a learning exercise and not as a way of apportioning blame.

1.2.5 The rationale for the review process is to ensure agencies are responding appropriately to victims of domestic violence by offering and putting in place

appropriate support mechanisms, procedures, resources and interventions with an aim to avoid future incidents of domestic homicide and violence.

- 1.2.6 The review also assesses whether agencies have sufficient and robust procedures and protocols in place, which are understood and adhered to by their staff.

1.3 Terms of Reference

- 1.3.1 The specific terms of reference agreed for this review were:

- Were there any indications of difficulties within family relationships?
- Was there any history of abuse by Bob towards his parents or towards others, including his wife or children?
- Were there indicators of vulnerability in relation to Joe or Iris? Were there any indicators that Bob had a caring role within the family?
- Were there any concerns relating to substance use or mental health issues in the case of either the victims or alleged perpetrator? Were these acted upon appropriately? In what way may these have impacted in relation to any domestic abuse, or the responses by agencies? Consider if the interplay between domestic violence or abuse, substance use and/or mental health issues, may have led to any 'narrowing of focus' and the failure to explore other issues.
- Were there any indicators of any financial difficulties? If so, to what extent may they have impacted upon family relationships?

In addition to the above, IMR authors were asked to give consideration to the questions included within Appendix 1 of the Home Office's Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews.

- 1.3.2 The time period covered by the review was from 1st October 2012 until the day of the homicides. In addition IMR authors were also asked to summarise and address any relevant and significant events prior to this review period. These are events that are felt to provide context to the homicides, the risk posed by Bob, the vulnerability of Iris or Joe, or information relating to any of the key issues identified within the terms of reference.

1.4 The Review Panel

- 1.4.1 The review Panel membership was as follows:

Kath Albiston	Independent Chair and Overview Report Author
Mary Burns	Newcastle Gateshead Clinical Commissioning Group (CCG)
Linda Gray	Newcastle City Council, Wellbeing Care and Learning Directorate
Jan Grey	Northumbria Tyne and Wear NHS Foundation Trust (NTW)

Maureen Gavin /Peter Walton	National Probation Service (NPS)
DCI Shelley Hudson	Northumbria Police
Helen Lamont	Newcastle upon Tyne Hospitals NHS Foundation Trust (NUTH)
Anne Marshall	Northumberland Victim Support Service (VSS)
Christine McManus	North East Ambulance Service NHS Foundation Trust (NEAS)
Neil Scott	Your Homes Newcastle (YHN)
Anna Stabler / Bev Walker	NHS England
Lesley Storey	Domestic and Sexual Violence Coordinator, Safe Newcastle
Robyn Thomas	Safe Newcastle

1.4.2 The Chair and Overview Report Author is a qualified Probation Officer and prior to leaving the Probation Service worked within a joint Police and Probation unit acting as Chair for Multi-Agency Public Protection (MAPP) meetings. Working independently as a consultant and trainer since 2006 she has undertaken a variety of roles within the domestic violence and safeguarding arena, working with statutory and voluntary sector agencies around the writing of risk assessment tools, policy and procedure, and the training and clinical supervision of staff. She has also undertaken service reviews and scoping exercises in relation to provision of domestic violence services. Alongside her involvement with a number of Domestic Homicide Reviews, the author also currently acts as an ‘expert witness’, writing domestic abuse risk and vulnerability assessments for public and private law cases.

1.4.3 The Independent Chair/Overview Report Author had no involvement with Iris, Joe or their son, or any supervisory responsibility for any of the professionals’ work being reviewed.

1.5 The Review Process

1.5.1 The review consisted of the following key eventss:

11/02/15	Initial Panel Meeting at which terms of reference were agreed. This meeting was rearranged from 12/01/15 due to an emergency evacuation of the meeting venue.
09/03/15	Individual Management Review (IMR) authors meeting.
11/06/15	Agencies’ IMRs submitted.
02/07/15	Panel and IMR authors meeting – presentation and review of IMRs. An additional IMR was sought as a result of this meeting.
03/08/15	Meeting with Northumbria Police’s Senior Investigating

	Officer to discuss the outcome and content of the trial and family contact.
27/10/15	Panel meeting to review the Overview Report.
02/11/15	Meeting with Iris's daughter, Charlotte.
November - February	Obtaining and reviewing of information into 999 call placed by Iris on day of homicides.
15/02/16	Final Panel meeting to review detail of 999 call and extent to which this had been addressed.
09/03/16	Further meeting with Charlotte – at which it was agreed she would produce a statement to aid with the review. Review put on hold awaiting this.
July 2016 – January 2017.	Postponement of submission of final report due to sickness absence of Chair/author. Home Office notified.
22/02/17	Further meeting to finalise review and ensure full consideration given to daughter's statement.

1.5.2 Individual Management Review (IMR) reports were completed by the following agencies:

- Newcastle Gateshead Clinical Commissioning Group (CCG)
- South Tyneside Clinical Commissioning Group (CCG)
- Newcastle upon Tyne Hospitals NHS Foundation Trust (NUTH)
- Northumberland Tyne and Wear NHS Foundation Trust (NTW)
- Adult Social Care, Newcastle City Council, Wellbeing Care and Learning Directorate (ASC)
- Your Homes Newcastle (YHN)

1.5.3 All IMR authors were independent of the case and had no previous contact with Joe, Iris or Bob, either as a practitioner or through the management of staff involved.

1.5.4 All other Panel members confirmed that they had had no relevant contact with Joe, Iris or Bob that would warrant the completion of an IMR, although the North East Ambulance Service provided a summary of their contact on the day of the homicides. In addition, a number of third sector agencies were contacted and confirmed that they had had no contact relevant to the review. These were Newcastle PROPS, North East Council on Addictions (NECA), and Women's Aid. Finally, as the perpetrator was known to have children, contact was made with Children's Services to see if they had any relevant records. Newcastle Children's Services confirmed they had no relevant records.

1.5.5 The review process was not completed within six months due to a number of reasons. Firstly, completion of IMRs led to identification of a further IMR being required from South Tyneside CCG. Secondly, the family could not be fully involved in the review until after the trial had concluded; this was due to their potential involvement in the court case. Upon conclusion of the trial, a

meeting took place with Iris's daughter Charlotte; this raised a significant concern regarding a 999 call that was placed by her mother on the day of the homicides. As all other information had been reviewed regarding agency contact and relevant action taken, the Panel agreed it was acceptable to extend the timeframe of the review in order to fully explore issues regarding this 999 call. The purpose of this was to ensure that steps being undertaken to review the call were comprehensive, and to decide whether a separate IMR was required for the purpose of this review. It took considerable time to obtain the relevant information and satisfy the Panel that sufficient consideration had been given to this issue within other review processes. This significantly impacted upon the timescale for completion of this final report, although any actions identified by agencies were not delayed as a result.

- 1.5.6 In addition to the above, Joe and Iris's daughter Charlotte contributed significantly and provided a full statement to the review process, which is discussed further in section 1.7. It was felt important to take the time to enable this involvement.
- 1.5.7 Prior to publication of this report all those who had input into the review process were given the opportunity to comment upon the report, and any changes considered necessary were made so accordingly.

1.6 Profiles of Agencies Involved and IMR Methodology

- 1.6.1 **Newcastle Gateshead Clinical Commissioning Group (CCG)** is the statutory body responsible for planning, purchasing and monitoring the delivery and quality of local NHS healthcare and health services for the people of Newcastle and Gateshead. Their IMR was completed by the CCG's Safeguarding Adults Officer, with supervision and support provided by the Designated Nurse for Adult Safeguarding. The completed report was reviewed by the Designated Nurse for Adult Safeguarding and approved by the CCG's Medical Director and Executive Director of Nursing, Patient Safety and Quality. In order to complete the IMR the General Practitioner (GP) medical records of Joe, Iris and Bob were reviewed.
- 1.6.2 **South Tyneside Clinical Commissioning Group (CCG)** represents 27 GP practices in South Tyneside and covers a population of 153,000. They became a statutory body in April 2013 and have responsibility for commissioning a wide range of local health services cross South Tyneside. Their IMR was completed by the Safeguarding Adults Lead Professional, with supervision from the Head of Safeguarding. The IMR was approved by NHS England Cumbria and North East. In order to complete the IMR the GP medical records of Bob were reviewed, and the General Practitioner involved with the case was also interviewed.
- 1.6.3 **Newcastle upon Tyne Hospitals NHS Foundation Trust (NUTH)** is one of the largest acute, teaching, Trusts in the UK, employing over 14,000 staff,

and delivering healthcare services from a number of sites within the Newcastle area. The IMR for NUTH was undertaken by a Community Matron within NUTH, currently working in The Children's Services Directorate. Supervision during the process of writing the report was provided by one of the Trust's three Deputy Directors of Nursing. The report was approved by the Nursing and Patient Services Director. In order to complete the IMR medical records of all relevant parties were reviewed, and four members of staff were interviewed. In addition, the author met with the Safeguarding Training Lead to discuss the Safeguarding Training provision for staff working within the organisation.

1.6.4 **Northumberland, Tyne and Wear (NTW) NHS Foundation Trust** is one of the largest mental health and disability trusts in England. It works from 100 sites across Northumberland, Newcastle, North Tyneside, Gateshead, South Tyneside, Sunderland and North Easington and serves a population of 1.4 million. The NTW NHS Foundation Trust's IMR was undertaken by the Head of Safeguarding and Public Protection. In undertaking the review all paper and electronic records were examined.

1.6.5 The IMR for **Adult Social Care (ASC), Newcastle City Council** was undertaken by the Learning Disability Team Manager, and the report was reviewed and authorised by the Acting Assistant Director of Adult Social Care, Wellbeing Care and Learning Directorate. For the purpose of the IMR Specialist Services electronic records were studied, and an interview was undertaken with the Social Worker previously involved with Iris and Joe.

1.6.6 **Your Homes Newcastle (YHN)** is an Arms Length Management Organisation responsible for managing council homes on behalf of Newcastle City Council. The IMR for YHN was undertaken by the Income Recovery Manager for the West End area of Newcastle upon Tyne, and was supervised and approved by YHN's Director of Tenancy Services. In order to complete the IMR computer and paper based tenancy records held by YHN were reviewed.

1.7 **Family Input into the Review**

1.7.1 Telephone discussions took place with Joe's brother and Bob's ex-wife to explain the review process and invite them to participate. Joe's brother did not feel that he had anything he wished to contribute, but agreed that he would like to be informed of the outcomes of the review process. Bob's ex-wife stated that she could not understand why a review was taking place, as there had been no previous issues warranting agency involvement. She declined to have any further involvement with the review process.

1.7.2 Iris's daughter, Charlotte, agreed to meet with the Chair as part of the review process and contributed extensively, including the provision of a statement to the Panel. The Panel wishes to express gratitude to Charlotte for her level of involvement.

- 1.7.3 The review process also identified that Joe had a daughter from a previous marriage. Further enquiries revealed that they were estranged and no contact details were available.

1.8 Criminal Proceedings

- 1.8.1 Bob maintained that on the night of the murders, men had broken into the family home and killed his parents, as well as attacking him. However, in June 2015 Bob was convicted, following trial, of Joe and Iris's murder and received two life imprisonment sentences, with a minimum length of thirty five years.

1.9 Coroner's Inquiry

- 1.9.1 The Coroner's Inquest did not result in any further information being shared that was felt relevant to this review.

1.10 Other Reviews

- 1.10.1 As already indicated, information obtained during the course of this review indicated that a 999 call had been placed by Iris on the day of the homicides, This was reviewed by BT, the 999 liaison committee, and the National Police Chiefs Council's Contact Management Steering Group. As this was a significant event in relation to the homicide, and an issue raised by Iris's daughter Charlotte, the extent and outcome of the review by these other bodies was considered fully by the Panel; the details and outcomes of which are included within the body of this report.
- 1.10.2 Charlotte also made a complaint to Northumbria Police regarding the Police's conduct of the investigation, and the focus on Bob as the alleged perpetrator. This matter was being dealt with separately and was not felt relevant to the terms of reference of this review.
- 1.10.3 No other parallel reviews were identified as taking place.

1.11 Confidential Information

- 1.11.1 For the purpose of this review Bob was contacted, via his solicitor, requesting his permission for disclosure of confidential records. This was granted on the understanding that Bob continued to maintain his innocence in relation to the murders. It is also for this reason that, after consideration, the Panel decided not to interview Bob directly in this case.
- 1.11.2 Full consideration was given to the need to anonymise or redact any necessary information prior to publication, in line with Home Office Guidance for the completion of DHRs.

CONCLUDING REPORT

2 THE FACTS

2.1 Family structure and background

2.1.1 Joe and Iris were a white British couple who married in 2001, and were living together in the Newcastle area at the time of their deaths. As well as having an adult son together, Bob; they each had an adult daughter from previous relationships.

2.1.2 In June 2006 Iris had an operation to remove a benign brain tumour and post operatively suffered a stroke, following which she received many years of neurological rehabilitation, and required some care and support within the home. During this time Joe acted as her primary carer, eventually giving up his job with the Council.

2.1.3 The couple's son Bob had been married previously, and had two children within this relationship. He was believed to be separated from his wife at the time of the murders and residing with his parents.

2.2 Summary of Relevant Agency Involvement prior to the Review Period

2.2.1 A number of agencies identified information prior to the review period that was felt to be relevant in providing context to events that followed. A summary is provided below separately in relation to Iris, Joe and Bob.

Iris

2.2.2 Prior to the review period, Iris appeared to be in good health until she began experiencing a number of neurological symptoms, which included that which she described as 'funny turns'. Following referral to a Neurologist in November 2005 by her GP, she was diagnosed with temporal lobe epilepsy, which appeared to spontaneously resolve. At that time her neurological examination was normal and she was awaiting an appointment for an MRI scan. The scan was eventually carried out in January 2006 and identified a benign brain tumour. The neurological symptoms were increasing as a result of the tumour, and such symptoms included loss of vision in the right eye.

2.2.3 Iris was admitted to hospital on 07/03/06 for surgery, but sadly post-operatively suffered a stroke with resultant left sided weakness. During the post-operative recovery it was noted that she was tearful and unhappy about the length of her recovery, and was treated with low dose antidepressants. It was documented that she did then start to feel better, and this coincided with her transfer to the Regional Neurological Rehabilitation Centre, where she remained as an inpatient until October 2006.

- 2.2.4 Adult Social Care first became involved at this time, with a referral being made to the Physical Disability Team. In May 2006 a Social Worker (SW1) was allocated to undertake a Community Care Assessment of Iris. This was completed on 28/10/06. Iris, Joe, and Bob, were all noted as living together and as each having been consulted during the assessment. Joe was referred to as Iris's carer, with Bob described as 'supportive'. The family was also described within records as 'insular'. One risk that was identified was that Joe could 'over-help or 'help inappropriately due to alcohol consumption'.
- 2.2.5 SW1 also completed separate Risk Need Summations for Iris and Joe on 26/10/06, and a Care Plan and FACE¹ Risk Profile on 27/10/06. The Care Plan included the commissioning of a one-hour support visit per day by Age Concern, and two days per week for Iris at a Day Service. The risk status was identified as low apparent risk in two domains – Domestic Risk and Risk Related to Physical Condition. The risk assessment also noted concern raised by the Rehabilitation Team regarding Joe's alcohol use, affecting his ability to care for Iris. The Carer's view of the risk was recorded as 'Iris's husband is aware of the risk of alcohol affecting his ability to care for Iris'. The presence of Bob at home was cited as a protective factor.
- 2.2.6 A multi-disciplinary meeting took place prior to Iris's discharge, which was attended by her husband, daughter and son. Discharge plans indicated that Iris was to return to her home address where Joe and Bob were living, and that a home care package and the implementation of a number of adaptations to the home were to be put in place. Within the IMR for ASC it was noted that although Iris had become wheelchair dependent, her speech and cognition were unaffected.
- 2.2.7 Post discharge (October 2006) Iris received Rehabilitation Services in respect of aspects of daily living, physiotherapy, dietetics, orthotics and regular outpatient appointments with a doctor at the local Neurological Rehabilitation Clinic. Records reviewed by NTW indicated that on a number of occasions Bob accompanied her to appointments. At these appointments Iris always gave permission for him to stay in the room when routinely asked.
- 2.2.8 A further Care Plan for Iris was completed by SW1 on 30/10/06 (subsequently reviewed by SW1 on 24/04/07 and 07/06/07). Her level of need was identified as 'substantial'. The Carers Support Section indicated that there was short break funding to enable Joe and Iris to spend time away from usual routines and responsibilities of daily life. A Short Break (Direct Payment) letter of agreement was completed by SW1 and signed by Iris. The agreement outlined two weeks short break per year commencing 01/04/2007.
- 2.2.9 A Review of Iris's Care Plan was undertaken by SW1 at her home on 24/04/07 and both Iris and Joe were present. The Age Concern Home Care Manager was also consulted via telephone. Iris's comments were recorded as

¹ 'Functional Analysis of Care Environments' - an assessment tool nationally accredited by the department of health

follows:

'Iris is happy with the support she receives from the care worker from Age Concern. Iris cancels the care when (HCW1) is on holiday or unable to come as she does not want another care worker she does not know to assist her with personal care. Iris stated that she is getting around the house quite well due to the compact layout. The house has recently been rewired and refurbished through the current renovations programme by Your Homes Newcastle. Iris's level-entry shower is now in place and a permanent ramp has been fitted to the rear of the property. Iris is pleased with the renovations and she feels she is more independent now that the adaptations to the shower-room are in place. Iris's employment terminated on the grounds of ill health'.

2.2.10 The comments of 'family/friends/informal carer' were recorded as:

'Joe feels he is coping well with his caring responsibilities. He feels they would manage without the support of Age Concern but he and Iris do not want to offend HCW1, the care worker, as she has been very supportive to both of them. Joe is now in receipt of Carer's Allowance.'

2.2.11 On 04/05/07 SW2 supported Iris to attend the Different Strokes Group. Records noted that Iris attended with her husband and that Bob collected them.

2.2.12 SW1 transferred Iris's case to the Review Team in September 2007. A formal review was to be undertaken by SW3 but there is no confirmation or evidence within case notes that this was carried out.

2.2.13 In December 2007 a telephone call was received from Age Concern advising that the worker working with Iris was due to retire on the 24/12/07. Iris had advised them that she did not want anyone else, stating that she could manage by herself. Telephone calls were made by SW4 to both the service provider and Iris, which confirmed that Iris did not want a replacement and felt she would manage without care, as she had good family support.

2.2.14 SW4 recommended case closure on 10/12/2007. Day service support was cancelled but the service package history indicates that Direct Payments for Short Breaks remained open.

2.2.15 In January 2009 a review was undertaken by SW3. The review noted that 'Overall Joe is happy with the support and manages to provide his wife with the care needed at this time. If for any reason Joe is unable to provide the standard of care in the future he is aware advice/information can be obtained via the duty team on the number given.' Current needs, interventions and outcomes recorded within the review were 'Visual impairment, suffered stroke resulted in mobility restrictions. Assistance required with holiday break to allow for much needed respite time and carer relief.' It was concluded that

the opportunity to access funding for Short Breaks via direct payments would continue in order to promote independent living for Iris.

- 2.2.16 When considering whether planned outcomes were being achieved, the following was recorded by the review officer:

'Iris confirmed the opportunity for a holiday break is continuing to provide her with respite time away from the setting of her home. Overall Iris seemed happy with the opportunity to get away and currently Iris's overall care needs are being met by her husband. Iris described the break as a time 'to get away' which is essential for her and her husband as much of their time is devoted purely to getting through, from day to day, which can have a big impact on their quality of life. Currently Joe assists with all daily living tasks and personal care tasks. Joe also assists with all meal preparation and shopping tasks. All household tasks are managed through Joe at this time. Iris's home has been adapted and a stair lift is in place, the bathroom has a walk in shower which is very helpful. The back of the property has access outside via a ramp. Iris is in receipt of the appropriate benefits receiving DLA and job seekers allowance.'

- 2.2.17 On 05/04/09 a closure of Direct Payments for Short Breaks was noted within Adult Social Care records, with no evidence of review or recorded activity to signify the reason for this. This is the last contact by Adult Social Care.

Joe

- 2.2.18 Joe appeared to be in good health and was working for the Council until 2000, when he fell approximately four feet from a trailer, fracturing his right heel. This injury required admission to hospital in January 2000 for internal fixation of the fracture.
- 2.2.19 At a GP consultation in February 2006 Joe presented with a post-traumatic wound infection and he was given a prescription for anti-depressants and a fit note (sick note) for two weeks. He returned to see the same GP in March 2006 complaining of stress and anxiety related to his wife's recent brain surgery; a further fit note was issued for an two weeks. At this consultation Joe's blood pressure was noted to be elevated, and a referral to the Practice Nurse was made by the GP for further checks.
- 2.2.20 In April 2006, the Practice Nurse (PN) saw Joe and a general review was carried out. Joe admitted that he was drinking 5 to 6 two litre bottles of cider a week, which equated to 70 - 90 units per week. Advice was given by the PN to reduce his alcohol intake, as this was more than twice the maximum recommended amount for men. The PN saw him one month later for follow up and, in reply to an enquiry by the PN regarding his wife, Bob stated that he was feeling more positive as Iris had begun to regain some function of the affected side since her stroke.

- 2.2.21 In the afternoon of 27/06/06 Joe attended the ward where Iris was an inpatient. Records note that he appeared upset, and Iris and Joe left the ward to talk to each other in a quiet area. A nurse approached Iris, who said she was happy to leave the ward with her husband. The nurse then waited a few minutes before checking on her. Iris's husband then took her out of the hospital into the rear car park, apparently against her will. He was recorded as laughing and ignoring Iris, despite her protests for him to return her to the ward. Joe refused to return her indoors. A staff member managed to distract him and a porter was able to return Iris to the ward. A nurse went to see Joe, who was lying on the grass in the rear car park. He denied having had a drink until advised that he would therefore have to be sent to hospital, as his speech was slurred and he was staggering. He then finally admitted having had a drink and it was recorded that, as the day was very hot and sunny, he may also have been dehydrated. Joe was informed that it was not appropriate to visit the hospital in such a condition. No further concerns were identified within health records.
- 2.2.22 In June 2006, Joe presented for a GP consultation with the same GP he had seen earlier that year, stating that he was confused and his mood was low. At this consultation he admitted that he was drinking one litre of cider a day since his wife had been admitted to hospital following a stroke. The GP referred Joe to the in-house counselling service, and an appointment was sent to him for August 2006, which he did not subsequently attend.
- 2.2.23 On 01/09/06 a Social Worker from Adult Social Care sent a letter to Neighbourhood Services on Joe's behalf, in support of his request for early retirement from the Council to enable him to care for Iris.
- 2.2.24 A letter was sent to Joe's GP practice by SW1 on 23/05/07. The letter was written on behalf of Joe, stating he had difficulty expressing his health concerns and symptoms which included: confusion, talking to himself, going into a daze; burning sensation in lower leg; pins and needles and numbness in hands; head pain; forgetfulness; insomnia. The letter also made reference to difficulties with hearing and cognition as well as noted weight loss and mood swings. It also stated that Iris had a concern about his drinking, although it also references that Joe reported drinking much less than he used to.
- 2.2.25 Two days later, on 25/05/07, Joe saw a GP at his practice and presented with multiple issues. These included a poor appetite, insomnia, vomiting blood and a labile mood. At this consultation he informed the GP that he had reduced his alcohol intake since last year and also reported that he was 'not keen' on counselling, which was why he had not attended the previously arranged appointment. The GP prescribed a different type of anti-depressant, and Joe was asked to return in two weeks for review.
- 2.2.26 Throughout the above period Joe also had a number of outpatient referrals to NUTH for health problems including, breathing problems and epigastric pain.

These conditions were investigated. On one occasion it was documented that he attended the appointment with his son (15/02/2011). During an outpatient appointment (18/08/2008) he also revealed heavy alcohol consumption, but then at his next outpatient appointment (18/12/2008), he reported that he was abstinent from alcohol. There were no further references to alcohol intake with NUTH's records.

Bob

- 2.2.27 In 2006 Bob registered with the same GP practice as his mother, and was reported to be residing with his parents at that time. He presented at the practice in October 2006 stating he was feeling tense and irritable as a result of a number of stressors, which he felt were impacting upon his life. He explained to the GP that his mother was very ill following surgery for a brain tumour and that his father had 'taken to drink'. Bob felt that he was coping with all the household duties, and, in addition, he was working full-time and undertaking some course work. As a consequence of all this Bob reported that he was extremely irritable and commented that his girlfriend had remarked on this fact. The GP recorded that Bob was coping very well under the circumstances, but was finding it stressful. With Bob's consent, a referral was made to the Primary Care Mental Health team. He was offered temporary medication, but declined this saying he was 'not keen' on taking any medication.
- 2.2.28 In November 2006 Bob attended the surgery for his appointment with the Primary Care Mental Health Team. The Practitioner recorded that the presenting complaint was irritability and anger, and that they felt that Bob was coping remarkably well with a difficult situation, which was slowly resolving. The Practitioner reassured Bob that his reactions were a normal response to the high levels of stress that he was under and that his behaviour was not extreme. Further observations were recorded that Bob was able to express his feelings and that he was an effective communicator. No follow up appointments were made, but Bob was made aware that he could return in the future for support if needed.
- 2.2.29 In April 2007 Bob had a head CT scan due to his report of persistent headaches. The scan was apparently normal and the opinion of the Consultant, expressed in a letter to the GP, was that the headaches were migraine related, which may have been exacerbated by the stress of his mother's illness.
- 2.2.30 On 02/01/08, Bob attended NUTH's Accident & Emergency department as he had reportedly punched a brick wall, injuring his hand. It is recorded that he was extremely intoxicated and he told staff that he had drunk approximately twenty units of alcohol; although he also reported only drinking occasionally. Treatment was given and he was referred to the Plastics Clinic for urgent review of the injury. The review identified that immediate surgery was required and he was admitted to hospital overnight. Following the surgery he

was discharged the next day with analgesia and antibiotics.

- 2.2.31 In September 2009, Bob attended his GP practice for a further consultation with the same GP he had seen in 2006, complaining of a persistent headache for two weeks and a low mood. Bob went on to explain that he had been doing lots of extra work and that he was feeling tired. Bob was prescribed medication for the headaches.
- 2.2.32 YHN records indicate that during the above period Bob lived with his mother until 24/01/2010, when he moved to another area in Newcastle upon Tyne with his wife.
- 2.2.33 Two years later, in June 2011, Bob attended his GP practice, this time seeing a different GP, and again complained of a chronic headache. At this time Bob blamed the physical symptoms on the stress caused by his parents' ill health. The GP prescribed medication for the headache and discussed with Bob the possibility that he may be overusing analgesic medication.
- 2.2.34 On 30/07/2011 YHN records indicate that Bob moved to a different address within the Newcastle area with his wife.
- 2.2.35 Bob consulted with the same GP approximately one year later, in July 2012, again presenting with a two to three week history of daily headaches and blaming stress at home. Bob explained that he had a baby of 4 months old and this was affecting the relationship with his wife and they were not getting on well. In addition, he also informed the GP that he was looking after his parents and felt unable to work at present. The GP issued a sick note for two weeks as a result of this consultation.
- 2.2.36 Bob returned the following month, on 20/07/12, and consulted with a different GP. At this consultation, Bob complained of continuing headaches and stated that he was under extreme stress. Bob described how his mother was severely disabled and his dad was in hospital for investigations of alcohol problems. The GP also recorded that Bob was having work problems, and had a young son, who was not sleeping, and that Bob was worried. The GP re-started medication for migraine.

2.3 **Key Events and Contact by Agencies during the Review Period (01/10/2012 until the day of the homicides)**

- 2.3.1 During the review period Adult Social Care had no continuing contact with Iris. Both Iris and Joe had contact with their GPs, with Iris attending one consultation with a GP and one consultation with the Practice Nurse, and Joe attending three consultations with GPs and one consultation with the Practice Nurse. The content of such contact was not felt relevant to this review process. It was however noted on Joe's records that he was a carer for his wife. Joe also had two attendances at NUTH's departments during the review period, again for medical issues not relevant to this review.

- 2.3.2 Iris was also regularly reviewed at the Rehabilitation Clinic and it was documented that she continued to require support with activities of daily living, was mobile with a stick at home, and required a wheelchair outdoors. It was also noted that she was taken shopping and out on trips by her son and daughter in law. Recording for one of the clinic appointments also indicated that she attended with her son. Iris's GP received letters detailing the outcomes of these reviews.
- 2.3.3 YHN records indicate that Bob made a joint re-housing application with his wife that resulted in a move to a tenancy in South Tyneside on 18/10/12.
- 2.3.4 On 09/05/13 Bob first registered with a GP Practice in South Tyneside. No significant health needs were identified at the registration appointment and Bob reported that he did not smoke or drink alcohol. No further contact was made with the GP Practice until September 2014.
- 2.3.5 In October 2013 Iris had a routine chronic disease review with the Practice Nurse. A general review of her physical needs, psychological needs and social needs was undertaken, and no specific problems were identified at that time.
- 2.3.6 On 14/04/14 Iris attended a final appointment with the Rehabilitation Consultant. In a letter to her GP regarding this appointment, it was stated that she was accompanied by her son on this occasion, and that she was coping at home with support from her husband. It was recorded that Iris had also stated that her mood was 'up and down', but never persistently low. Iris was discharged from the care of the Neurological Rehabilitation Clinic at this appointment.
- 2.3.7 On 15/09/14 Bob attended the GP Practice in South Tyneside requesting a sick note following bereavement. He stated that his father, who was an alcoholic, had committed suicide by slashing his wrists. Bob stated that his father had telephoned the night before asking for help and Bob was blaming himself for not doing something about it. He also reported that his mother was ill with a brain tumour, and that he had 2 children. The GP discussed bereavement, issued a fit note (sick note) for two weeks and advised Bob to self-refer to South Tyneside Talking Therapies, a counselling service provided by South Tyneside NHS Foundation Trust (STFT).
- 2.3.8 On 24/09/14 Bob attended the GP Practice again, requesting a further sick note due to the stress of the bereavement. He stated that he was waiting for an appointment to see a counsellor from Talking Therapies and also requested something to help him sleep, informing the GP that he was 'picking on his partner and children'. A fit note was issued for four weeks.
- 2.3.9 On 31/10/14 Bob once more attended the GP Practice with bereavement issues. He stated that was not coping well, and was tearful. He stated that

talking to his mother was not helpful as she thought he could have done something to prevent his father from killing himself. Bob reported that he had spoken to Talking Therapies and was seeing them again; although checks completed following the homicides by the GP confirmed that Talking Therapies had received no contact from Bob. Bob also stated during this consultation that he was not getting along with his partner. The GP offered reassurance that he could not have prevented events and discussed possible coping strategies, advising that Bob stay in touch with Talking Therapies. The GP prescribed an anti-depressant and issued a fit note for a further four weeks. This was followed by a further fit note being issued on 20/11/14 for eight weeks. There was no further contact with the GP Practice.

- 2.3.10 On 05/11/2014, Bob's wife made a sole application for rehousing and this application was accompanied by a supporting letter from her Health Visitor which indicated a relationship breakdown with Bob. Following this, on 07/11/2014, Bob made a sole application for rehousing, however, he did not fully complete this application and it was not verified.

2.4 **Day of the homicides**

- 2.4.1 According to information made available to this review, on the day of her death Iris placed a 999 call which was received by the BT call handling centre. Information provided to this review indicated that the handset was replaced at the caller's end after three seconds. There was said to be no signs of disturbance or distress, and though a brief muffled voice could be heard, what was being said was indistinguishable. During the criminal investigation, enhancement equipment was used on the call, which revealed that something such as 'please hurry up' may have been said. However, it was not believed this would have been heard by the operator handling the call. The operator was reported to have stayed on the line for a further forty five seconds after the handset had been replaced, thus keeping the line open should the caller wish to re-engage. As there was no indication of distress, and no further communication was received, the call was not connected to the Police.
- 2.4.2 A 999 call was later received via North East Ambulance Service (NEAS) control from a neighbour. The caller stated that two of her neighbours had been stabbed in their home. The victim's son was reported to have knocked on her door and stated that someone had ran in the house and stabbed his parents. The call was triaged via NHS Pathways and a response generated, with two rapid response vehicles, Hazardous Area Response Team (HART), and an ambulance being dispatched. An on call officer was also dispatched once the situation became clear.
- 2.4.3 An information call was then received via NEAS control from Northumbria Police to advise that officers had arrived at the address prior to NEAS. Ambulance and Rapid Response Units were advised that it was safe to proceed to scene.

- 2.4.4 At the scene, Joe was found lying on his back with an obvious head injury to the left side of his head that was about 5 inches long and moon shaped. A small pair of scissors was found lying by his head. Iris had been found with a ligature around her neck.
- 2.4.5 On arrival of ambulance crews CPR was being performed on Joe by a police officer already on scene, and was taken over by the Emergency Care Support Worker on their arrival. Advanced Life Support was commenced and the first paramedic on scene worked between managing two patients in cardiac arrest. Both Iris and Joe were taken to hospital and later pronounced dead.

3 FAMILY PERSPECTIVE

- 3.1 In meeting with the Chair of this review and a representative of Safe Newcastle, Iris's daughter Charlotte identified that she did not believe that her brother was guilty of her parents' murder and instead thought that the perpetrators came from outside the family. She expressed concern regarding the Police's handling of the investigation and their focus on her brother. Charlotte made a complaint to the Police as a result of this, and acknowledged that this was beyond the remit of this review process and was being dealt with separately.
- 3.2 Within a statement provided to the review Charlotte described her family as follows:

'I am, and continue to be, in awe of my mother. Her strength inspires me every day. When I think of how much she endured and survived throughout her life, it humbles me. She was a fighter, and not a person to be pitied. That is the last thing she would ever have wanted. If I live to be even half the person she was, I will be happy.'

She loved musicals, and had an infectious sense of humour. My mother was witty, sharp, didn't miss a trick, kind and unintentionally hilarious. When needed, she would tell you straight but never judged and was always there when you needed her. She had warmth that drew people to her and a beautiful soul. She, like my father, loved music.

The respect and love I have for my father knows no bounds. He was not my biological father, but he was my Dad in every sense of the word, taking me on as his own when I was two years old. He knew me better than I knew myself and despite the issues with my biological father was there to support me when I needed it. He adored my mother and was always so loving towards her; she was his absolute world and he hers.

My father had a laugh that was contagious, a proper belly laugh that cackled, especially when he found something hilarious. He didn't miss a thing either, gave me space, respected my feelings and decisions I made, and never

made me feel bad about myself. My husband asked for his permission to marry me and he walked me down the aisle on my wedding day. My husband and I were witnesses at their wedding, and he was a devoted grandad to our sons. We had plans for the future. We were looking forward to the grandchildren having sleepovers at theirs, and had discussed a family holiday.

Yes, like all families, we had problems, but it's so important to me that I convey there were many, many wonderful times. We endured our share of tragedies and setbacks but this only made my parent's stronger. My father's devotion to my mother and us only ever grew. I have been candid on how the loss of my son and my mother's tumour affected us all, yet at the time of this tragedy we were closer than ever.

Both my parents were sticklers for manners and had their own 'funny little ways', when it came to the routines of the house. I feel that I have tried, in vain at times, to express these traits in order to have people understand that these idiosyncrasies are things all families have in some capacity. They were both very independent, and apart from a few reasons, relied on no one. They chose who they wanted to have in their lives.

They are my inspiration and have taught me the true meaning of family.'

3.3 Charlotte expressed that her family had been misrepresented in court and in the press, and that agencies had a false perception of them as people. She felt that following her parent's death, when she was spoken to by agencies they focused on the negative, such as her mother's disability and her father's problems with alcohol. Charlotte described this as just one aspect of who they were, and that they were not defined by either. She stated that she would '*categorically deny that (her) parents were in any way vulnerable*', that she could '*state with absolute certainty that they did not view themselves in this way*', and that this was '*backed up by the minimal intervention from agencies that could have been available to support my parents, had they needed it. They refused all care support, as they were independent and self-sufficient enough to live together without intervention or enhanced care. The notion that my parents were reliant on my brother so much that they were burdensome is absolutely preposterous. They were very proud of how independent they were.*'

3.4 Charlotte went on to describe how her parents '*found their own coping strategies that worked for them. (Her) mother was able to be mobile around her home, provided she had her leg brace and walking stick. She could be left alone while (her) father went shopping, and as she almost always kept the house phone underneath her clothing, my father felt comfortable enough to leave her unsupervised. She was able to answer the door, and care for herself in so many more ways than she has been given credit for. This reality completely contradicts this picture of an isolated couple who lived in fear. They were, quite simply, private by choice, and only allowed a small circle of family members into their lives. They answered the door, but were selective*

about who they let into their home; even then, no one went upstairs.'

- 3.5 In discussing this review, one significant issue raised by Charlotte was the 999 call placed by her mother on the day of the homicides. She spoke of her frustrations in getting information in relation to this and felt that agencies had not been forthcoming in providing this to her.
- 3.6 Charlotte undertook much research into the details of this call and supplied the review with the information she had received. The critical point for Charlotte was that she felt that her mother's request for police was audible, if quiet, and therefore should have been connected to emergency services. In addition, she did not believe the call was disconnected after three seconds as information provided had suggested, but rather that her mother may have muted the call. Charlotte felt that the guidance for the filtering of calls, in which it is stated that there is an 'underlying rule' that if there is any doubt or suspicion the call should be connected, relied on the judgment and opinion of the call taker.
- 3.7 Charlotte outlined in detail her concerns about the filtering of the call, and the quality of the equipment used to listen to call, including the lack of enhancement. She expressed frustration at the lack of response she received to specific questions relating to this and that details of the 999/112 committee review of this were not made public. She reported that there 'was no doubt in (her) mind after listening to (her) mother's 999 call that had this been passed to Police control then both (her) parents would still be alive now'. The 999 call is addressed further within the agency analysis within section 4 of this report.
- 3.8 Finally, within her statement, Charlotte spoke of her experience as a victim of crime through the murder of her parents. Much of this related to a complaint Charlotte had raised with Northumbria Police about the investigation and prosecution of her brother; however, this was not felt by the Panel to be within the remit of this review. Charlotte also raised this issue with the Independent Police Complaints Commission (IPCC), although it did not meet the criteria for appeal against investigation of a complaint. In addition, Charlotte also raised concerns about the availability, independence, and level of support offered by the Police's Family Liaison Officer and Victim Support. She felt that at time their roles were unclear and indistinct. She said that the liaison between the two meant that she did not feel entirely comfortable in talking openly, given the police's involvement in the investigation of her brother. Charlotte also felt that more signposting should have been provided around who could provide support for her young son to deal with the impact of the murder of his grandparents. She spoke of how this was not forthcoming and initially left him without access to appropriate support, which was eventually obtained through her husband's employers. As a result of these latter issues, a recommendation was made by this review to enable Charlotte's concerns about her experiences as a family member to be considered in more detail.

Recommendation: Victim Support and Northumbria Police

- Meeting to be arranged with Charlotte to consider her experience following the murder of her parents and whether this can be used to inform processes and support offered to family members.

3.9 Charlotte provided a comprehensive document relating to the concerns outlined briefly above. This was shared with all Panel members for consideration by all agencies.

4 ANALYSIS OF AGENCY INVOLVEMENT

4.1 Detailed below is the analysis of agencies' involvement with Iris, Joe and Bob. This is taken both from individual agency IMRs, as well as consideration given by the author of this report to each agency's involvement within the broader context of this review.

4.2 Newcastle Gateshead Clinical Commissioning Group (CCG)

4.2.1 The IMR completed on behalf of Newcastle Gateshead CCG originally covered Bob's contact with his GP within South Tyneside from May 2013. However, due to issues around this contact identified within the IMR, it was agreed that a separate IMR was needed on behalf of South Tyneside CCG; which was completed and is considered further below. In light of this, information taken from the IMR for Newcastle Gateshead CCG will solely address issues Bob's contact with his GP practice in the Newcastle area.

4.2.2 Within Newcastle Bob attended the same GP practice as his mother, whilst Joe was registered with a different practice. As has been noted, within the review period Joe and Iris's contact with the GP practice was limited and not felt to be relevant to the terms of reference for this review.

4.2.3 The IMR for Newcastle Gateshead CCG identified no known difficulties or indicators of abuse in the family relationships between Iris, Joe and Bob, either during or prior to the review period. Joe was recorded as Iris's carer, and Bob was noted to offer support such as accompanying her to appointments and taking her out. It is of note that both Iris and Joe appear to have been seen alone at a number of appointments, and therefore there were safe opportunities for disclosure of any concerns. While the fact that no disclosures were made does not indicate conclusively that there were no issues, it is nevertheless important that circumstances that would have allowed for disclosure existed.

- 4.2.4 As regards contact with Joe, in 2006 he attended two appointments with his GP (March and June 2006) and two appointments with the Practice Nurse (April and May 2006) in relation to issues of stress and anxiety, and various other issues. He also made reference in both appointments with the GP to his wife's situation. Appropriate responses appear to have been given to Joe's presenting needs; he was referred to the Practice Nurse for further exploration of symptoms on the first occasion, and to counselling on the latter. It is unclear as to whether further exploration took place with him regarding the impact of Iris's ill health. However, there was evidence of good practice in his contact with the Practice Nurse when at the second appointment she enquired directly as to the situation with his wife.
- 4.2.5 In relation to Bob's contact with his GP practice, he reported on a number of occasions that he was feeling irritable or experiencing stress. This included in October 2006 when he reported that his mother was very ill, his father had 'taken to drink', and that he had taken on all the household duties. As a consequence, he identified that he was extremely irritable and that his girlfriend had commented on this. The GP responded to the presenting difficulties appropriately by referral to the Primary Care Mental Health team. However, there does not appear to have been any exploration of wider issues, such as the impact of Bob's stress in terms of his reported caring responsibilities within his parents' home. Similarly in Bob's contact with the Primary Care Mental Health team, little further exploration seems to have taken place regarding any caring role he may have.
- 4.2.6 Bob then presented on a number of occasions, albeit spread over a number of years (April 2007, September 2009 and June 2011), with symptoms of persistent headaches, which were often attributed to stress. While he was prescribed medication for the headaches, and on one occasion, referred for a scan, there seems to have been little exploration of any underlying issues that may have been causing the headaches.
- 4.2.7 On 20/07/12 Bob again presented with persistent headaches and described stress at home. Within this appointment he also spoke of having a 4 month old baby, and that he was looking after his son and felt unable to work. He then presented again two weeks later, and reported the same problems to a different GP, who prescribed medication for migraines. Once more there is no evidence of exploration regarding underlying issues, or the impact that the stress may have in relation to either his wife or young son, or to his parents whom he reported to be supporting.
- 4.2.8 The IMR author identified that the symptoms that Bob was experiencing could have triggered further exploration regarding the impact upon his close family relationships, including selective enquiry regarding domestic abuse and information regarding his son. The IMR highlighted that GP's are encouraged to undertake selective enquiry for domestic abuse and there is an increasing

awareness of this in primary care with awareness raising and relevant best practice guidance, for example, from the British Medical Association.

- 4.2.9 Furthermore, the identification that Bob was a carer for his parents may have benefited from further enquiry about the nature of the caring role that Bob was adopting, and he could have been referred to Adult Social Care for a Carer's assessment if appropriate. As a carer, Bob would have been entitled, at that time, to a Carer's assessment in his own right under the Carers (Recognition and Services) Act 1995. The GP could have discussed this with Bob and, with his permission, made a referral on his behalf or encouraged him to self-refer. An assessment would have allowed needs in relation to any caring role to have been identified, and may have resulted in an increase of the support provided for his parents.
- 4.2.10 In relation to the above, the IMR author also identified that Iris was also vulnerable due to her care needs following a stroke. She was being supported by her husband with minimal input from home care, at her and Joe's request. It was highlighted that Iris's ability to promote her own rights and interests may be compromised due to her dependency upon others for some of her care needs. While the GP who saw Bob may not have been aware of the extent of his mother's support needs, or Bob's role in relation to these, further exploration of this may have led to consideration of the impact of Bob's difficulties in relation to any potential risk to his mother.
- 4.2.11 In summary, the IMR author identified that when Iris, Joe or Bob consulted their GP practices, their medical problems were dealt with as they arose. Referrals were made to appropriate agencies to deal with the presenting problem, or treatment was prescribed by the GP. The overall impression was that the primary health care team responded reactively to presenting medical problems, but there appeared to be little exploration of the wider impact for the patient and their family.
- 4.2.12 The reasons for this were felt, by the IMR author, to be understandable in the context of GP workload pressures. There is statutory guidance now in place as a result of The Care Act (2014) which puts the needs of carers on an equal legal footing to those that they care for. This means that carers are entitled to request a carers assessment from Adult Social Care to determine their own needs for additional support and the primary health care team can help to facilitate this by raising awareness with the individuals concerned. The IMR author also identified that the Newcastle Unit of Delivery practice development and engagement programme for 2015/2016 has taken a keen interest in carers and promoting the role of Primary Health Care Teams in supporting carers. This programme follows on from the Caring for Carers conference held in February 2015 and is encouraging practices to nominate a young and older persons carers champion within their practice. This is aimed at raising the profile of carers and their specific needs for support in their caring role and there is a defined action plan which the practice will be

encouraged to implement which includes early identification of carers and subsequent coding on the I.T. systems; awareness raising for all practice staff through training; robust action plans to ensure that the needs of carers are addressed; and engagement with carers and carers groups. This work aims ensure that the carers agenda will be embedded within practice for primary health care teams.

4.2.13 The GP practices involved in this review now both have a Domestic Violence Policy and Adult Safeguarding Policy, and clinical staff are encouraged to access training in both of these areas of practice. However, cases such as this, where no disclosure or significant indicators of concern were identified, would not prompt any action by GPs under these policies; unless further exploration led to concerns.

4.2.14 The recommendations arising from the IMR for Newcastle Gateshead CCG were that all GP Practice staff should be encouraged to attend Domestic Violence training to raise their awareness of this issue, have regard to the impact of domestic violence upon the wider family unit, and to recognise the interface between safeguarding and domestic abuse; that Newcastle Gateshead CCG should continue to support GP Practices across the City to promote the needs of carers within Primary Health Care Teams; and finally, that the review has highlighted that GP's and clinical staff in primary care need to explore the wider implications, and potential risks, of an individual's presentation and behaviours. The 'Think Family' agenda includes children and others with vulnerabilities, and this issue will be emphasised in training.

4.3 **South Tyneside Clinical Commissioning Group (CCG)**

4.3.1 Following his registration at the GP Practice in South Tyneside in May 2014, Bob consulted with the GP on four occasions between September and November 2014. Bob informed his GP that his father had committed suicide and indicated that he felt guilty that he could have done more to prevent this. It is now known of course that, at the time of these consultations, his father was alive, however it is recognised that there was no reason for the GP to have questioned what Bob told him.

4.3.2 The rationale for Bob fabricating his father's death is not known, nor whether there were other factors that may have contributed to this. However the IMR author identified that Bob did achieve an outcome, on the basis of the fabrication, by obtaining sickness certifications and, on the third consultation, a prescription for anti-depressants.

4.3.3 Information shared by Bob to the GP also indicated that family relationships were tense, not only with his mother but also with his partner and his children. Bob had informed the GP that his mother had a brain tumour and, during the third consultation, he suggested that their relationship was not good, as his

mother felt he could have done more to prevent his father's alleged suicide. Bob also informed the GP on 13/9/14 that he was 'picking on his partner and children', and on 31/10/14 that he was 'not getting along with his partner.'

- 4.3.4 When interviewed the GP's recall was that the phrase 'picking on his partner and children' was as stated by Bob. No further exploration was undertaken around this statement, or consideration given to domestic abuse. The GP explained that his perception of the poor relationships was as result of the alleged nature of the bereavement, and the family as a whole struggling to come to terms with the situation. Whilst this would appear a reasonable assessment of the situation, the IMR author noted that poor mental health is clearly evidenced as a factor related to domestic abuse. On recognition that Bob's mental health was not improving at the consultation on 31/10/14, in the prescribing of anti-depressants, and the further disclosure of a poor relationship with his partner, the GP missed a further opportunity to enquire about domestic abuse.
- 4.3.5 In addition, the GP did not perceive that there were potential safeguarding issues relating to the children. Whilst safeguarding children, in the broadest terms, should always be a consideration, the IMR author concurred, that the limited information available to the GP would not have reached the threshold to make a referral to Children's Services. However, it must be recognised that further enquiries should have been made by the GP to ensure the safety and wellbeing of the children.
- 4.3.6 In relation to this, the IMR also noted that there were no next of kin (NOK), partner or children's details recorded on Bob's record, and without these details any referral or sharing of relevant information would not have been possible. Without this information, GPs would also not be aware if family members were registered at the same GP Practice to enable cross reference as required, unless a search was undertaken of addresses to understand who resided with the patient. This method has limitations however, as relationship details would still not be understood.
- 4.3.7 On interview, the GP explained that currently NOK/partner/children details are not routinely collected and documented. Only children who are subject to a child protection plan have parents' details recorded to allow cross reference as required. As a consequence, the GP was not aware if Bob's partner and children were registered at the same practice, which was an omission on the part of the GP, particularly when relationship difficulties were disclosed by Bob.
- 4.3.8 A recent Safeguarding Adults Review (SAR) in South Tyneside has recommended that NOK/partner details are routinely recorded by all GP Practices at the point of registration, and updated as required to ensure the appropriate support and intervention is offered as required. Action to implement this recommendation was being progressed at the time of writing

this report, and should ensure that this includes the recording of any children's details.

- 4.3.9 Bob also disclosed to the GP that his mother had a brain tumour, which although this was recognised as a stressor, it was not accompanied by any exploration of whether Bob had a caring role, which would have allowed a more accurate assessment of need in relation to Bob. It would also have helped in consideration of any safeguarding concerns in relation to his mother, given Bob's presentation and his reports of conflict within the relationship. While it is recognised that it is unlikely that any information revealed by Bob would have highlighted any safeguarding concerns, given the false nature of the story he had presented to the GP, further exploration should nevertheless have been prompted in the circumstances.
- 4.3.10 In interview with the IMR author the GP explained that the consultation time for each patient is very limited, and as Bob's difficulties were perceived as relating to bereavement, albeit compounded by his mother's illness, he appropriately advised Bob to seek self-help via Talking Therapies. This service, provided by STFT within the community in both South Tyneside and Gateshead, provide interventions for individuals experiencing mental health difficulties, in particular anxiety and depression. The GP felt that this service had the expertise to explore the issues faced by Bob in greater detail and offer relevant interventions. Verbal information regarding the service was given to Bob and also a service leaflet with the contact details. It was then believed that Bob made contact with Talking Therapies and was receiving ongoing support, as referenced during his appointment on 31/10/14.
- 4.3.11 The GP subsequently contacted Talking Therapies, following the homicides, to understand if Bob had had attended any appointments, and was informed that there was no record of any contact having been made. The DHR Panel considered whether the GP should have followed up with Talking Therapies as to whether Bob had attended. It was recognised however that it would be highly impractical for GPs to routinely follow up self-referrals to support services and that this would only occur if it was felt that the person's difficulties were not improving over a significant period of time, or there were increased concerns. In addition, this led to discussion of whether Bob should have been referred to Talking Therapies in the first instance by the GP, rather than leaving him to self-refer. It was concluded however that the GP's actions were in line with NICE² guidelines around treatment and referral advice for mild to moderate symptoms relating to mental health concerns. Within this it is noted that low level intensity interventions should be initially offered, with anti-depressants offered as a follow up only in cases where the symptoms persist of having been present for long periods.³ It was also not felt that having directly referred Bob would have changed outcomes in this case.

² National Institute for Health and Care Excellence

³ NICE guidelines (CG123): 'Common mental health problems: identification and pathways to care'

- 4.3.12 Good practice was noted by the IMR author in relation to the GP's appropriate consideration of the presenting mental health needs of Bob, including advising self-referral to Talking Therapies, discussing possible coping strategies, and only prescribing anti-depressants when deemed necessary. However it was also highlighted that poor mental health in perpetrators and victims is clearly evidenced as a factor related to domestic abuse. It has been highlighted that domestic abuse is not always identified because agencies are focusing on addressing other issues, including the mental health of individuals (Domestic Homicide Reviews Common Themes Identified as Lessons to be Learned, Home Office 2013), and the IMR author concluded that this could be attributed to this case. As a result it was recommended that all South Tyneside GPs access domestic abuse training. E-learning courses are readily available to GPs via The Royal College of General Practitioners and South Tyneside Safeguarding Children Board (STSCB), with face to face training also available via STSCB. GPs also receive training on their roles and responsibilities regarding domestic abuse at Safeguarding GP Education Forums, and updates at the Safeguarding GP Leads Forum. Further advice and training is currently available from the Domestic Abuse GP Link Worker as part of the START (South Tyneside Abuse Response Team)⁴ Project but it should be recognised that this resource was not available until January 2015, and therefore not available at the time of the homicides.
- 4.3.13 A further two recommendations were made within the IMR for South Tyneside CCG. Firstly, that all GPs should be aware of the correlation between poor mental health, substance misuse and domestic abuse to ensure exploration of all issues and appropriate actions can be made to ensure the safety and welfare of all. Secondly, that all GP Practices should routinely document next of kin / partner / children details at the point of registration and update as required, to ensure the appropriate support and interventions can be offered.

Cross-referencing of learning and recommendations for Newcastle Gateshead CCG and South Tyneside CCG

- 4.3.14 The completion of two separate IMRs for Newcastle Gateshead CCG and South Tyneside CCG, has allowed specific focus on Bob's presentation to each practice. Whilst there are some issues specific to different presentations, the themes emerging from both IMRs are similar, particularly as the Newcastle Gateshead CCG IMR originally considered all contact with Bob across both practices. In light of this both Newcastle Gateshead CCG

⁴ The START (South Tyneside Abuse Response Team) project, funded by Northumbria PCC, involves the appointment of a Domestic Abuse Health Link Worker for 18 months to support Primary Care within South Tyneside. The specialist worker will develop an agreed pathway to improve levels of safety; provide training and support to the 27 South Tyneside GP practices; act as consultant to whom general practices can directly refer patients for specialist advocacy in established community based health settings primarily via specialist 'drop-in' type clinics. The expected outcome of this service is to demonstrate significant improvement in GP Primary Care responses to disclosure and identification of abuse, offering improved life chances to those families affected by domestic abuse, who live, learn and work in the locality.

and South Tyneside CCG agreed to implement recommendation within each other's respective IMRs.

4.4 **Newcastle upon Tyne Hospitals NHS Foundation Trust (NUTH)**

4.5 NUTH's contact with the family was minimal during the review period and was in relation to medical issues not felt to be relevant to this review. As regards such health needs, the IMR identified that services provided both during and prior to the review appeared to be appropriate to the presenting conditions at the time.

4.5.1 At no point during Iris, Joe or Bob's contact during, or prior, to the review period were there any indications of difficulties within family relationships, or of abuse or violence by Bob.

4.5.2 Some limited information was available prior to the review period regarding Joe and Bob's alcohol use, as assessments of alcohol intake were included in clinical assessments. Joe revealed heavy alcohol intake in August 2008 but this was reported to have reduced by December 2008. Bob was described as intoxicated in 2008, but stated he only drank occasionally. This was not explored further given the context of a one off Emergency Department attendance, and his report that he had no ongoing issues in relation to alcohol use. While he stated that he punched a wall, which would appear to be an aggressive act, there was nothing to indicate anyone else was involved and this was the sole incident of this nature in his presentation to NUTH.

4.5.3 It was also evident from The Newcastle upon Tyne Hospitals NHS Foundation Trust medical records that Iris had a degree of vulnerability due to her disability and was reliant on Joe to meet her needs. However, there were no indicators of concern apparent within her contact with NUTH to suggest she was at risk.

4.5.4 Bob was recorded as offering some support to his mother, through shopping and trips out, but he was not identified as a formal carer. Again there was no evidence of any concerns in relation to this role or his relationship with his parents.

4.5.5 The IMR identified that NUTH Trust currently have a Safeguarding Adults policy and procedure. When someone is identified as an Adult at Risk and abuse is suspected, such policies and procedures must be followed. All staff also have a defined responsibility to acknowledge domestic violence or abuse and attend training that raises awareness of domestic violence and abuse, and of the Multi Agency Risk Assessment Conference (MARAC) process. They also have supporting policies and procedures in place for the use of the DASH risk assessment and risk management of domestic violence.

- 4.5.6 No lessons to be learned were identified in relation to NUTH's involvement with Iris, Joe or Bob, and as a result no recommendations arose from this review.

4.6 **Northumberland, Tyne and Wear NHS Foundation Trust (NTW)**

- 4.6.1 NTW's contact was solely with Iris and took place between 2006 and 2014, during her attendance at the Neurological Rehabilitation Clinic. During this time there was no known history of domestic abuse within the family and no indicators of abuse identified by staff. The IMR author noted that Iris was seen alone during the provision of personal care and this would have allowed the opportunity for disclosure of any concerns.

- 4.6.2 As regards the one occasion in June 2006, when Joe attended the ward under the influence of alcohol and removed Iris from the ward against her wishes, the IMR author identified that staff viewed this as a reaction to Iris's recent hospitalisation. There were no other such concerns at future visits. Practitioner's assessment and response to the situation would appear to have been appropriate. This could perhaps have triggered further direct enquiry with Iris around domestic abuse, although the fact that it did not is understandable in light of the context and lack of any other concerns. In addition, at this stage Iris remained an in-patient and therefore there was no immediate risk related to the possible impact of the stress Joe may have been experiencing in dealing with his wife's condition. While the Panel noted that Joe's behaviour in this incident could have been seen as indicative of coercive control, there was no further evidence to support this in his contact with NTW staff. NTW also identified that direct enquiry around domestic abuse is now a part of all assessments and therefore would be explored should an incident such as this occur in the present day.

- 4.6.3 The IMR author also reported that there was nothing identified within the health records to indicate there were any issues within the family. It was seen that Bob brought Iris to appointments and offered information to clinicians when asked regarding her wellbeing. One of the doctors (Dr D) involved in Iris's care informed the IMR author that she remembered Iris as a lady who spoke up for herself, and had a drive to improve her mobility post operation. Dr D observed Bob to be caring towards his mother, and keen to know the outcome of any brain scans that would offer reassurance that a tumour had not developed. Dr D was also aware that Joe was discussed in appointments with Iris as her carer. No concerns were brought to the attention of Dr D from any other professional involved in Iris's care.

- 4.6.4 NTW has had a Domestic Abuse Policy in place since 2013, which includes the DASH risk assessment and pathways for domestic abuse. The Trust Safeguarding and Public Protection Team have three expert practitioners that provide advice, support and supervision to all staff across the trust in respect of Domestic Abuse.

4.6.5 No lessons learned were identified in relation to NTW as a result of this review, and this no recommendations were made within the IMR.

4.7 **Adult Social Care, Newcastle City Council, Wellbeing Care and Learning Directorate (ASC)**

4.7.1 Adult Social Care, Newcastle City Council, had active contact with Iris from 2006 to 2009. As regards the appropriateness of this contact in responding to Iris's care and support needs, the IMR author identified that interventions and assessments from Social Workers and Occupational Therapists were timely and appropriate, and that there was clear evidence within case notes that decisions were responsive to the needs of both Iris and Joe, as her carer.

4.7.2 As regards, the lack of documentation regarding the ending of Direct Payment (DP) for Short Breaks, the reasons for this were not recorded as they should have been. However, the IMR author identified that this appears to have been due to Iris's none engagement with the required DP audit; therefore due to her failing to return monies from the first DP audit and subsequent non-engagement with a further audit, Direct Payment was ended.

4.7.3 As regards the family situation, the IMR identified that SW1 did not recall Bob being present during home visits carried out after Iris's discharge from hospital; although did recall him attending some team reviews whilst Iris was in hospital. However no concerns were identified as regards his relationship with his parents, nor were there any concerns or indicators of abuse. As a result of Bob's limited presence the focus of the IMR for ASC is primarily in relation to their contact with Joe and Iris as a couple, and whether there is any learning around practice that can be taken from this.

4.7.4 During interview as part of the review process Social Worker 1 (SW1) recalled that Iris would have been entitled to more paid supports, but chose to accept a minimum level of seven visits per week. Iris also turned down the offer of additional day care support following an initial visit and chose to turn down further assistance when her support worker left the provider organisation.

4.7.5 For the duration of their involvement, SW1 remembered Iris and Joe as a loving but quite private couple. SW1 had numerous visits with Iris whilst she was in hospital, and recalled Joe as the main visitor. During his visits to the ward, Joe was often observed as very tearful, and concerns were also noted by members of the Multi Disciplinary Team (MDT) regarding this.

4.7.6 Joe continued working while Iris was an in-patient and he would come straight to hospital from working all day. SW1 also recalled that Joe did sometimes arrive on the ward having had a drink with his work colleagues at

the end of a shift, but there were no concerns regarding alcohol dependency. SW1 was concerned about Joe's vulnerability and spent time talking to him about how he was coping with Iris's hospitalisation, and whether Joe was using alcohol as a coping strategy. When questioned, assurances were given to SW1 that drinking at the end of his shift was more due to the culture of the team in which Joe worked.

- 4.7.7 SW1 believed Joe was very traumatised by the outcome of Iris's operation and the impact of her subsequent stroke. Although very well intentioned in terms of offering his support to Iris, MDT members felt he may have 'over assisted' her. Iris at times became agitated by Joe 'fussing' over her. However, she was also very reluctant to let others assist and support her.
- 4.7.8 SW1 felt that Joe 'absolutely adored his wife' and never had any concerns in respect of abusive behaviour from him. SW1 did recall a minor conflict arising between Iris and Joe following his redundancy. Prior to her operation, Iris had indicated she had managed the family finances. Joe did not share the detail of his redundancy package with Iris and this became the source of the conflict between them., although no more information was available around this.
- 4.7.9 In respect of later home visits by SW1, Joe was reported to always be sober and there were no noted incidents or concerns in respect of abusive behaviour in the family household. SW1 confirmed that SW2, in his role as Sensory Support Rehabilitation Officer, would also have undertaken visits to the household and did not bring any area of concern to SW1's attention as the allocated social worker. SW1 also noted that there were no indications that Iris was intimidated into making different decisions by Joe or anyone else.
- 4.7.10 The IMR author noted that during the time period of Iris's contact with workers within Wellbeing Care and Learning Directorate (2006-2009), it was not clear that Newcastle City Council had specific policies and procedures in place for risk management of domestic violence victims or perpetrators, although Newcastle City Council did have a Domestic Violence policy in place. The author also noted that SW1 has since completed the Safeguarding Domestic Violence training and has experience in completing and working with Newcastle Multi-Agency Domestic Violence and Abuse Procedural Flow Chart and the MARAC Risk Identification Checklist. The author felt that had there been any indicators or disclosures, SW1 had the knowledge and skills to act appropriately and refer on appropriately.
- 4.7.11 In conclusion, the IMR for Newcastle ASC identified that there were no indications or concerns in relation to any domestic violence within the household, and that Bob remained essentially absent from the picture.

- 4.7.12 The review has identified that there were some factors that perhaps could have prompted selective enquiry with Iris regarding abuse, namely Joe's earlier alcohol use, his apparent stress in coping with Iris's condition, and the reported financial conflict. Recent Domestic Homicide reviews within the local region have also highlighted the need to recognise carer stress as a risk factor in relation to domestic abuse and the need for this to prompt selective enquiry with those being cared for. It is recognised however that ASC involvement occurred from 2006 to 2009 and such practice would not then have been routine. In addition, in the absence of any history of abuse, or other indicators, these factors on their own would not be obvious prompts. Furthermore, there is evidence of good practice and a proactive response to Joe as a carer, with SW1 having explored concerns with Joe regarding his own vulnerability, the concerns having been noted in assessments, as well as records reflecting direct consideration and discussion of Joe's role as a main carer.
- 4.7.13 As a result of this review just one recommendation was identified within the IMR for ASC, namely, to ensure a clear record of all changes to care packages is entered on Carefirst by Social Work staff.

4.8 **Your Homes Newcastle**

- 4.8.1 The IMR author for Your Homes Newcastle did not identify any involvement with the family that was relevant to the terms of reference. It was noted within the IMR that during routine contact by YHN no difficulties within family relationships were identified within records, or any indicators that Bob had been abusive to his parents, his partner or his children. There were also no concerns raised within YHN contact around substance misuse or mental health in relation to Iris, Joe or Bob.
- 4.8.2 The IMR author also recorded that during the review period YHN had policies and procedures for (DASH) risk assessment, and risk management for domestic violence and abuse; however no events or indicators were identified that would have triggered the use of these.
- 4.8.3 It was concluded by the IMR author that YHN acted appropriately in all contacts with Iris, Joe and Bob, which were in reality minimal. No lessons to be learned from this case were identified in relation to YHN's limited contact and as a result no direct recommendations made. However, the IMR identified that YHN is currently assessing the customer and business benefits of carrying out a regular customer service visit to tenants where they do not have any contact within a specified time frame. In addition, the tenancy agreement is currently under review and a requirement to allow YHN employees access to a property will be considered as part of this review process. These proactive steps will increase contact with those who may otherwise have limited contact with agencies, and would open up

opportunities for any indicators of abuse within the home setting to be identified.

4.9 **The '999' call**

4.9.1 The call placed by Iris on the day of her death was connected to British Telecom, who act as the 'Call Handling Agent' (CHA) for the emergency services and route emergency calls by connecting to the appropriate service. The day to day operational practices and procedures that are adopted between the CHA and the emergency services are documented in Public Emergency Call Service Code of Practice (PECS Code of Practice)

4.9.2 Information provided by BT indicated that about 30 million emergency calls are made each year from both fixed lines and mobile handsets. Call filtering for silent or near-silent calls where the caller does not, or cannot, respond to the 999 operator with a request for a given service (Police, Fire, Ambulance or Coastguard), means that calls are not always connected on to an emergency service. BT carries out this filtering at the request of the Police and uses processes agreed with them within PECS. Each day, approximately 20,000 calls are handled using these filtering processes, with about ten percent of these, in which there is no direct request for connection by the caller, being connected to the Police because there are some audible signs of distress or disturbance. In the case of Iris's call it was concluded that there were no audible indications on the call from Iris, with this only becoming known after the event when the call was enhanced for the criminal trial. As such the call was not connected, which was in line with the PECS code of practice.

4.9.3 A similar incident to that of Iris's call, also occurred in Wales previously and both calls were reviewed by the UK Government's 999 Liaison Committee, in relation to how BT is required to filter calls on behalf of the Police to see whether any improvements could be made. This was then referred to the National Police Chiefs Council's Contact Management Steering Group, who have responsibility for the development and implementation of policy in this area. This Group met on 29/09/15 and, taking both cases into account, concluded that with existing technology, the filtering process could not practically be improved.

4.9.4 As has been outlined Iris and Joe's daughter Charlotte has raised a number of issues regarding this process and the subsequent conclusions drawn by the reviewing committees.

4.9.5 It was difficult for the Panel to draw any further conclusions, particularly given the lack of access to first hand sources around the call. Consideration was given as to whether an IMR as needed in relation to this, however information supplied by the 999 Liaison Committee suggested this issue had been

reviewed in detail by themselves and the National Police Chiefs Council's Contact Management Steering Group; the Panel felt these were the appropriate and best placed avenues to review such concerns. All parties had also been made aware of Charlotte's concerns.

4.10 **Equality and diversity issues**

- 4.10.1 As part of the review process consideration was also given throughout to issues of equality and diversity. In the cases of Joe, Iris and Bob, there were no specific issues identified in relation to gender, race, religion, age, sexual orientation, or gender reassignment that were seen to be relevant to the review process. It is recognised that Iris met the definition of a 'Adult at Risk' due to her health and social care needs, but at no stage was she identified as being at potential risk by those working with her, and therefore no referrals were made under the Safeguarding Adults process.

5 **LESSONS LEARNED AND CONCLUSIONS**

- 5.1 The undertaking of this review has revealed limited contact with agencies by Iris or Joe, outside of that related to Iris's health and social care needs following her surgery in 2006, and the post operative stroke that she suffered. Subsequent to this Iris was in regular contact with agencies including NUTH, NTW, her GP and Adult Social Care within this Joe was identified as her main carer. Joe himself presented to his own GP in 2006 and 2007 with difficulties that appeared related to him coming to terms with his wife's condition. Such contact decreased over the years and from 2008 onwards the primary contact Iris had was in relation to her continued attendance at the Neurological Rehabilitation Clinic until 2014.
- 5.2 The picture that emerges is of Joe and Iris as a relatively private couple and as a result little information has emerged to present any clear picture of their family life by agencies, beyond that relating to Iris's recovery and Joe's role in caring for her. Within this, there has been some reference to their son Bob, who appeared to live with them for periods of time, and was mentioned by a number of agencies as attending appointments with Iris and offering support.
- 5.3 Within the above there was no evidence of any abuse, or any missed indicators, within Iris or Joe's contact with agencies. There is also evidence that both Joe and Iris were seen alone by agencies, giving them the opportunity to disclose any concerns.
- 5.4 As regards Bob, outside of his contact with professionals working with his mother, he too had limited involvement with agencies. He had no known history of violence or abuse, and indeed there were no indicators of this in his presentation to agencies working with his mother. Furthermore, while the Judge's summation in the criminal court case cited financial motivation on

Bob's part, this is not an issue that has been apparent within the information provided to this review. The sole reference to finances in any contact with agencies was some conflict between Iris and Joe related to him not sharing details of his redundancy package, however this dated back to before 2009.

- 5.5 In hindsight, through this review it can be seen that there were indicators of concern around Bob in the months leading up to the homicide. These included his apparent separation from his wife, the possible loss of his home, and the difficulties reported to his GP. Indeed, the only agencies that held relevant information in relation to Bob were the two GP practices with whom he was registered during the review period. It has been shown that he presented on a number of occasions, over a period of years, with complaints of anxiety and stress and persistent headaches. Relatively close to the homicides, in September 2014, he presented with similar complaints but also reported that his father had committed suicide. The reason for such a fabrication remains unknown. What is apparent is that when he also made disclosures of concern around his relationship with his partner, children and mother, and these were seen in light of his report that his father had died, which contributed to such disclosures not being pursued further. Indeed the learning identified from this review, though limited, focuses on the need to gather further information around people's home circumstances when stress or anxiety is reported, and to explore disclosures of conflict or distress in more detail. This can be seen to be particularly important in relation to the role of GPs, for as this review has demonstrated, in cases where individuals such as Bob have little contact with agencies, the GP may be the only one to whom any concerns are expressed.
- 5.6 It can be concluded that as a result of the limited nature of contact with agencies, the absence of any known history of violence, and the absence of any indicators of abuse by Bob towards his parents, the agencies involved in working with Iris, Joe or Bob, had no information available to them that would have allowed them to predict or prevent the tragic and untimely deaths of Iris and Joe.

6 SUMMARY OF RECOMMENDATIONS

6.1 Summary of recommendations arising from this review

Victim Support and Northumbria Police

- Meeting to be offered to Charlotte to consider her experience following the murder of her parents and whether this can be used to inform processes and support offered to family members.

South Tyneside Clinical Commissioning Group

- Where patients are presenting with mental health concerns and management of this is based on reports that they are receiving support from other sources, GPs should be encouraged, where possible, to verify this.

6.2 Individual agency recommendation identified within IMRs

Newcastle Gateshead Clinical Commissioning Group

- All GP Practice staff should be encouraged to attend Domestic Violence training to raise their awareness of this issue, have regard to the impact of domestic violence upon the wider family unit and to recognize the interface between safeguarding and domestic abuse. The training is available from Newcastle City Council and/or the Safeguarding Teams from NGCCG. An annual audit of training undertaken will be done by the Safeguarding Adults Lead NGCCG. Responsible – GP Lead for Safeguarding Adults NGCCG.
- NGCCG should continue to support GP Practices across the City to promote the needs of carers within Primary Health Care Teams. Responsible – Medical Director for NGCCG in partnership with the Clinical Strategic Director, Newcastle Unit of Delivery.
- This review highlights that GP's and Clinical Staff in primary care need to explore the wider implications, and potential risks, of an individual's presentation and behaviours. The 'Think Family' agenda includes children and others with vulnerabilities; this issue will be emphasised in training. Responsible – GP Lead for Safeguarding Adults NGCCG, Adult Safeguarding Leads in GP Practices and the Safeguarding Adults Team, NGCCG.

South Tyneside Clinical Commissioning Group

- All GPs should be aware of the correlation between poor mental health substance misuse and domestic abuse to ensure exploration of all issues and appropriate actions can be made to ensure the safety and welfare of all.
- All GP Practices should routinely enquire and document next of kin / partner / children details at the point of registration and updated as required, to ensure the appropriate support and interventions can be offered.

Adult Social Care, Newcastle City Council, Wellbeing Care and Learning Directorate

- Ensure a clear record of all changes to care packages is entered on Carefirst by Social Work staff.